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ABSTRACT

This study examined data from focus groups with New York City adolescents and interviews with health care providers serving New York City adolescents (hospital based clinics, school based health centers, child health clinics, community health centers, and a multi-service adolescent center) in order to determine how to promote health and reduce risk. Results indicated that the breadth, cost, and accessibility of health services provided to adolescents depended on the setting they selected to obtain care. The results highlighted five areas of concern in adolescent health: ensuring confidential treatment for adolescents, fragmentation of services, limited resources for health education and outreach, the health practitioner/adolescent relationship, and physical and structural barriers that make many health clinics less than adolescent-friendly. Recommendations are provided regarding the most common ways adolescents learn about health services; clinic environments; preferred appointment policy; health education; parental involvement in teen health decisions or treatment; relationships with primary care providers; and confidentiality. Three appendices present the site visit questionnaire, data questionnaire, and questions presented to teen focus groups. (SM)

PROMOTING TEEN HEALTH AND REDUCING RISKS:

A LOOK AT ADOLESCENT HEALTH

SERVICES IN NEW YORK CITY



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SERVICES IN NEW YORK CITY



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We thank the twenty-two health clinics that participated in our study for taking the time to inform Citizens' Committee for Children of New York, Inc. (CCC) about the services they offer to adolescents, and for the suggestions they shared for improving the delivery of adolescent health services. We also thank the members of the East Side Settlement House Youth Leadership Program for allowing CCC to elicit their opinions about the adolescent experience in seeking health care in New York City, and their ideas about how to make health services more user-friendly for adolescents.

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In a world with ready access to drugs, alcohol, guns, gangs, and illnesses, such as HIV/AIDS, health indicators show that the behavioral decisions that adolescents confront may have serious health and mental health implications. For example, in 1998 adolescents (15-24 year olds) in New York City had approximately one million hospital visits as a result of assault related injuries, almost twice as many as 25-34 year olds who had the next largest number of hospitalizations.¹ Adolescents are also at higher risk than adults for contracting a sexually transmitted disease.² Other behaviors, such as drug use and smoking, may lead to addiction and mask underlying mental health problems, such as depression and anxiety. When left untreated health, mental health, and/or substance abuse problems may result in poor academic performance, isolation from familial and other supports, low self-esteem, juvenile justice involvement, physical problems, and even death. In 1997, suicide was the third-leading cause of injury-related deaths in the United States among adolescents 13-19 years of age.³ These and other troubling health indicators raise important questions for parents/caregivers, health and mental health professionals, policy makers, school administrators, and advocates interested in promoting the healthy and safe development of New York City's adolescents: Are adolescents informed about health risks? Where do they obtain health information? Where do adolescents go for health care? Are health services organized and delivered in a way that promotes their access to care? What efforts are made to encourage adolescents to become smart health care consumers?

The decision to seek health care for suspected problems is an especially difficult one for adolescents. Unlike younger children who rely on parents and caregivers to tend to their health care needs, adolescents begin to make decisions, including health related decisions, on their own or in consultation with a peer. This is particularly true for health concerns that derive from behavioral decisions they have made and that they wish to keep confidential from their parents and sometimes even peers. Some of the

factors that may lead an adolescent to forego health care include: concern about confidentiality; fear about health examinations or the information yielded from an examination; an inability to pay for the services and/or lack of health insurance; difficulty making appointments; lack of transportation; and denying the seriousness of a condition.⁴ Most of these factors come into play regardless of an adolescent's health insurance status, although adolescents with health insurance are more likely to obtain health care than those without it.⁵

In 1999, Citizens' Committee for Children of New York, Inc. (CCC) conducted three studies that signaled the need for investigation into the availability and accessibility of adolescent health services in New York City.⁶ CCC responded by convening the Task Force on Adolescent Health in the Fall of 2000. The Task Force examined how health services are delivered to adolescents, the policies that encourage or impede access to health care, and whether adolescents are provided with the information needed to make decisions that promote, rather than threaten, their immediate and long-term health and safety. With a focus on primary care, CCC interviewed health professionals and administrators from twenty-two clinics that provided primary care to adolescents. We also elicited the teenage perspective on adolescent health services from a teen focus group. Through the interviews and focus group we learned about the efforts of primary care providers to encourage adolescents to obtain care when they need it and to provide health education and outreach to adolescents despite limited resources, training, and public investment. We also discovered regulatory, fiscal, and administrative impediments that obstruct adolescent access to health care.

Our findings show that as it stands now, the breadth, cost, and accessibility of health services provided to adoles-

1 *Assault Injuries and Deaths in New York City, 1998*, New York City Department of Health, Bureau of Family and Community Health Services, Office of Health Promotion and Disease Injury Prevention Program, p. 2. 25-34 year olds had 578, 500 assault-related injury hospitalizations in 1998.

2 *Health, United States, 2000 with Adolescent Health Chartbook*, U.S. Department of Health and Human Services, Center for Disease Control and Prevention, July 2000, p. 70.

3 *Ibid.* at 38.

4 C. Ford, P. Bearman, J. Moody, *Foregone Health Care Among Adolescents*, JAMA. 1999; 282: 2232; see also J. Klein, K. Wilson, M. McNulty, C. Kapphahn, and K. Collins, *Access to Medical Care for Adolescents: Results from the 1997 Commonwealth Fund Survey of the Health of Adolescent Girls*, J. Adolesc. Health. 1999; 25: 120-130.

5 *Ibid.* at 125-128; see also P. Newacheck, C. Brindis, C. Cart, K. Marchi, and C. Irwin, *Adolescent Health Insurance Coverage: Recent Changes and Access to Care*, Pediatrics. 1999; 104: 199.

6 *New York City's Child Health Clinics: Providing Quality Primary Care to Children in Low-Income and Immigrant Families*, Citizens' Committee for Children of New York, Inc. (January 2000); *Returning Home: A Look at Aftercare Services Provided to Delinquent Youth*, Citizens' Committee for Children of New York, Inc. (January 2000); *Can They Make It on Their Own? Aging Out of Foster Care - A Report on New York City's Independent Living Program*, Citizens' Committee for Children of New York, Inc. (January 2000).

cents depends on the setting they select to obtain care. Analysis of the data from site interviews and the teen focus group, identified five areas of concern in adolescent health: (1) ensuring confidential treatment for adolescents; (2) fragmentation of services; (3) limited resources for health education and outreach; (4) the health practitioner/adolescent relationship; and (5) physical and structural barriers that make many health clinics less than adolescent-friendly. We have grouped the findings according to these five areas in this report. Taken together, the findings presented

demonstrate the need for universal adolescent health policies and protocols throughout New York City, consolidation of health and mental health services, increased investment of resources and training in adolescent health, and targeted outreach and education efforts. Following each group of findings, CCC presents recommendations to New York City, New York State, managed care organizations, primary care providers and others interested in ensuring that adolescents are able to access the services they need to become healthy adults.

Where Adolescents Go for Primary and Preventive Health Care in New York City

With few exceptions, adolescents comprise a subset of a larger patient population in most health care settings, and, as a result, the way services are provided may not be tailored specifically to adolescents and their unique needs. For example, a hospital-based department of pediatrics serves children and adolescents ages 0-21, or a community health center serves patients of all ages, including adults. In addition, an adolescent and/or a parent may be hard pressed to locate an adolescent health care provider. New York City does not publish a comprehensive directory of adolescent health care providers. The New York City Department of Public Health (NYC DPH)⁷ publishes *A Guide to Social Services and Health Care in New York City*, which provides a listing of primary care providers and health education and prevention programs in each of the City's five boroughs. In some cases, the listings specify adolescents as a population served by a provider, and others do not. For children and adolescents enrolled in Child Health Plus A (Medicaid) or Child Health Plus B, the NYC DPH maintains the *HealthStat Provider Directory*, an on-line directory that lists individual health care providers by borough and indicates their area of specialty.⁸ This directory does not indicate providers who have a specialty in adolescent medicine. Finally, the United Hospital Fund publishes the *Directory of Ambulatory Care Facilities in New York City*.⁹ This directory lists facilities and organizations that provide primary care, women's health, and pediatric services. Except for identifying the few exclusively adolescent health centers, the directory does not indicate whether a facility has adolescent-specific programs or clinics.

New York City adolescents must choose among a handful of settings to go for primary and preventive health care. With the exception of only a few adolescent exclusive health centers, the choice of settings includes hospital-based or affiliated clinics, school-based health centers, community health centers, Child Health Clinics and Communicare Clinics operated by the New York City Health and Hospitals Corporation (HHC), and physicians in private practice.

School-Based Health Centers

A school-based health center (SBHC) is a health clinic located in elementary, intermediate, and high schools that provides students with primary and preventive health care. Some SBHCs also provide dental and mental health services or make referrals to community-based providers. A SBHC is affiliated with a back-up facility, such as a hospital or community health center, and usually staffed by a physician, nurse, nurse practitioner, or physician assistant, a social worker, and health assistant. Some SBHCs have additional staff, including health educators, nutritionists, and dentists. According to the New York City Board of Education, in the 1999-2000 school year there were 109 SBHC in New York City public schools, 21 of which were located in high schools and 33 in intermediate, junior high, and middle schools. SBHCs are licensed by the New York State Department of Health (NYS DOH), and funded with a combination of federal, state, local, and private dollars, and insurance reimbursement.

Child Health Clinics

As of August 2001, there were 29 Child Health Clinics open for operation in New York City. Child Health Clinics are housed in NYC DPH District Health Centers, public housing complexes and other City-owned buildings. Clinic staff typically includes: a pediatrician, a public health nurse, a public health assistant, a clinical clerk/medical records manager, and a laboratory associate. The Child Health Clinics offer a wide range of primary and preventive health care to adolescents and children without regard to insurance status or ability to pay. In 1998, 77,736 children received services at Child Health Clinics – 60 percent of whom were immigrants and approximately two-thirds had no insurance coverage.¹⁰

In 1994, New York City transferred oversight of the Child Health Clinics from the former New York City Department of Health to HHC, and Child Health Clinics were gradually integrated into the HHC hospital networks. In addition to the Child Health Clinics, HHC offers primary and preventive care to children and adolescents in its hospital-based departments of pediatrics, diagnostic and treatment centers, and Communicare Clinics.

7 In November 2001, a referendum was passed that approved the merger of the New York City Department of Health and the New York City Department of Mental Health, Mental Retardation, and Alcoholism Services into a single agency to be called the New York City Department of Public Health. The merger takes effect July 1, 2002.

8 www.nyc.gov/html/doh/html/stat/hprovide.html.

9 Available on-line at www.uhfnyc.org/pubs/guides/ambsite.html.

10 New York City's Child Health Clinics: Providing Quality Primary Care to Children in Low-Income and Immigrant Families. Citizens' Committee for Children, Inc. (January 2000), p. 6.

Community Health Centers

Community Health Centers, also known as Neighborhood Health Centers, are community-based clinics that provide comprehensive health services to medically underserved adults, adolescents, and children. Community Health Centers are supported by federal grants under the United States Public Health Services Act, and meet federal quality care, service, and cost standards. They typically offer prevention and primary treatment services as well as prenatal care, family planning, dental care, and nutritional services. Each of the Centers is uniquely committed to outreach in the community it serves. Fees are paid by third party medical insurance, Medicaid, or on a sliding scale basis. Similar to the Child Health Clinics, the policy of the Centers is that no patient will be turned away due to an inability to pay. In 2000, there were 24 Community Health Centers in New York City.

Adolescent Centers

Adolescent exclusive health centers are rare in New York City. For purposes of this report, an adolescent center or adolescent health center refers to organizations or clinics devoted exclusively to serving adolescents. For example, one clinic interviewed by CCC is part of an

organization that provides an array of services for adolescents only, and another clinic is affiliated with a hospital that serves adolescents in a free-standing building located several blocks away from the main hospital.

Guidelines for Adolescent Preventive Services

The American Medical Association developed the *Guidelines for Adolescent Preventive Services (GAPS)* to encourage primary care providers to adopt a holistic approach to providing health services to adolescents. The GAPS recognize the unique developmental stage of adolescents and the health and mental health risks they commonly face, and present 24 recommendations for providing preventive and primary care to adolescents. The majority of the recommendations focus on health education and screening for conditions that present risks to the immediate and long-term health of adolescents, such as obesity, substance abuse, sexual activity, mental health, and school-related problems. The recommendations also encourage providers to involve and educate parents about the health needs, risks, and services for their adolescents. The American Academy of Pediatrics has also issued several policy statements and protocols regarding the delivery of health services to adolescents.

GAPS*

(Guidelines for Adolescent Preventive Services)

Recommendations for delivery of health services

- Recommendation 1: From ages 11 to 21, all adolescents should have annual preventive services visits. Adolescents should have a complete physical examination during three of these preventive services visits. One should be performed during early adolescence (age 11-14), one during middle adolescence (ages 15-17), and one during late adolescence (age 18-21), unless more frequent examinations are warranted by clinical signs or symptoms.
- Recommendation 2: Preventive services should be age and developmentally appropriate, and should be sensitive to individual and sociocultural differences.
- Recommendation 3: Physicians should establish office policies regarding confidential care for adolescents and how parents will be involved in that care. These policies should be made clear to adolescents and their parents.

*American Medical Association: Guidelines for Adolescent Preventive Services, Recommendation Monograph.

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Recommendations for health guidance

- Recommendation 4: Parents or other adult caregivers should receive health guidance at least once during their child's early adolescence, once during middle adolescence, and, preferably, once during late adolescence.
- Recommendation 5: All adolescents should receive health guidance annually to promote better understanding of their physical growth, psychosocial and psychosexual development, and the importance of becoming actively involved in decisions regarding their health care.
- Recommendation 6: All adolescents should receive health guidance annually to promote the reduction of injuries.
- Recommendation 7: All adolescents should receive health guidance annually about dietary habits, including the benefits of a healthy diet, and ways to achieve a healthy diet and safe weight management.
- Recommendation 8: All adolescents should receive health guidance annually about the benefits of physical activity and should be encouraged to engage in safe physical activities on a regular basis.
- Recommendation 9: All adolescents should receive health guidance annually regarding responsible sexual behaviors, including abstinence. Latex condoms to prevent STDS, including HIV infection, and appropriate methods of birth control should be made available, as should instructions on how to use them.
- Recommendation 10: All adolescents should receive health guidance annually to promote avoidance of tobacco, alcohol and other abusable substances, and anabolic steroids.

Recommendations for screening

- Recommendation 11: All adolescents should be screened annually for hypertension according to the protocol developed by the National Heart, Lung and Blood Institute Second Task Force on Blood Pressure Control in Children.
- Recommendation 12: Adolescents with either systolic or diastolic pressures at or above the 90th percentile for gender and age should have blood pressure (BP) measurements repeated at three different times within one month, under similar physical conditions, to confirm baseline.
- Recommendation 13: All adolescents should be screened annually for eating disorders and obesity by determining weight and stature, and asking about body image and dieting patterns.
- Recommendation 14: All adolescents should be asked annually about their use of tobacco products including cigarettes and smokeless tobacco.
- Recommendation 15: All adolescents should be asked annually about their use of alcohol and other abusable substances, and about their use of over-the-counter or prescription drugs for nonmedical purposes, including anabolic steroids.
- Recommendation 16: All adolescents should be asked annually about their involvement in sexual behaviors that may result in unintended pregnancy and STDS, including HIV infection.
- Recommendation 17: Sexually active adolescents should be screened for STDs.
- Recommendation 18: Adolescents at risk for HIV infection should be offered confidential HIV screening with the ELISA and confirmatory test.
- Recommendation 19: Female adolescents who are sexually active or any female 18 or older should be screened annually for cervical cancer by use of a Pap test.
- Recommendation 20: All adolescents should be asked annually about behaviors or emotions that indicate recurrent or severe depression or risk of suicide.

- Recommendation 21: All adolescents should be asked annually about a history of emotional, physical, and sexual abuse.
- Recommendation 22: All adolescents should be asked annually about learning or school problems.
- Recommendation 23: Adolescents should receive a tuberculin skin test if they have been exposed to active tuberculosis, have lived in a homeless shelter, have been incarcerated, have lived in or come from an area with a high prevalence of tuberculosis, or currently work in a health care setting.

Recommendations for immunizations

- Recommendation 24: All adolescents should receive prophylactic immunizations according to the guidelines established by the federally convened Advisory Committee on Immunization Practices.

Fragmentation of Funding Limits Access to Comprehensive Adolescent Health Services

New York State and the federal government provide funding for a variety of health services for adolescents, but the funding is categorical in nature. For example, through Title X of the Public Health Services Act, the federal government provides funding for family planning clinics across the country. These clinics provide confidential family planning and reproductive health counseling, treatment and education to adolescents as well as adult women. Specific services funded by Title X include: pelvic examinations and pap smears, pregnancy options counseling and testing, contraceptive methods, and safer-sex counseling. Some of the clinics interviewed for this study receive Title X funding and other clinics with no Title X funding reported that they refer adolescents to family planning clinics in their community to get the care they need.

The federal Maternal and Child Health Services Block Grant (MCHSBG)¹¹ represents another source of federal funds that flows to states to fund a number of primary, preventive, and reproductive health initiatives. New York State relies on MCHSBG funds to support a variety of primary care, preventive and family planning services for women, adolescents, and children. Some examples of MCHSBG funded adolescent health and prevention programs in New York include school-based health centers, Assets Coming Together for Youth (ACT), pregnancy testing, community-based adolescent pregnancy prevention programs, HIV/AIDS prevention and treatment, and sexu-

ally transmitted disease prevention, detection, and treatment.¹²

Federal, state, and local grants also fund a variety of other child and adolescent health initiatives, such as abstinence education programs, childhood lead poisoning prevention programs, early intervention programs, child immunization programs, and many others.¹³ Finally, insurance reimbursement through Child Health Plus A (Medicaid), Child Health Plus B, or commercial insurance supports the provision of primary care to adolescents.

Although providing for the development of essential services, this categorical approach to public health funding forces providers committed to offering comprehensive preventive and primary health and mental health services to adolescents, as recommended by the GAPS, to piece together several funding streams. Difficulty in securing sufficient funding or in maintaining recurring funding over several years, generally means that services are not comprehensive and are often short-lived. In this way, current funding mechanisms contribute to the fragmented organization and delivery of health services and obstruct adolescents from getting the primary care they need.

¹¹ Federal funding for maternal and child health programs originated under Title V of the Social Security Act of 1935. Congress converted Title V into a block grant under the Omnibus Reconciliation Act of 1981.

¹² *New York State, Maternal and Child Health Services, Title V Block Grant Program, 2000 Annual Report/2002 Application*. ACT for Youth is a youth development/community development initiative that strives to produce positive outcomes for youth by focusing on prevention of violence, abuse, and risky sexual behaviors. ACT (Assets Coming Together for Youth) Factsheet, New York State Department of Health. ACT is supported with MCHSBG funds, the New York State Health Commissioner's discretionary funds, and the AIDS Institute.

¹³ *Catalog of State and Federal Programs Aiding New York's Local Governments*, New York State Legislative Commission on State-Local Relations (2001), pp. 254, 280, 288, 309.

In September 2000, CCC convened the Task Force on Adolescent Health to examine the health services available to New York City adolescents, to identify policies that encourage or discourage access to these services, and to understand what efforts are being made by health care providers to educate adolescents and prepare them to become good health care consumers. The Task Force was comprised of 28 lay and professional members, including CCC trained volunteers, CCC Board members, CCC staff, and 14 CCC YouthAction members.

YouthAction is a CCC program that develops the civic competency of 10th, 11th, and 12th grade students from public and private schools in New York City. Each year YouthAction provides participating youth with opportunities to identify, research, and address problems that affect their lives and the lives of other children and families in New York City.

To begin this effort, in October 2000, CCC hosted a policy briefing entitled "Adolescent Health: Reducing Risks and Improving Health Status" with a presentation by Warren Seigel, M.D., Chairman of Pediatrics, Director of Adolescent Medicine, Coney Island Hospital and President, New York Regional Society for Adolescent Medicine. CCC also conducted informational meetings with adolescent health care providers and administrators of City agencies, attended conferences on adolescent health sponsored by the Mount Sinai School of Medicine and the New York City Health and Hospitals Corporation, and attended community-based meetings to learn about the health care needs of adolescents and the organization and delivery of adolescent health services. We also reviewed professional literature, and federal and state statutes and regulations.

In December 2000, CCC contacted 104 health care providers that served adolescents to inquire about their interest in participating in the study. A total of 22 sites agreed to participate in a one-hour face-to-face interview, including eight hospital-based clinics, four school-based health centers, four HHC Child Health Clinics and one

Communicare Clinic, four community health centers, and one multi-service adolescent center. The sites were located in communities throughout New York City, including four in the Bronx, seven in Manhattan, eight in Brooklyn, one in Queens, and two in Staten Island. For purposes of reporting our findings, we refer to the sites as "clinics."

CCC developed and field-tested two survey instruments to interview health care providers serving adolescents. One survey instrument sought information about the services, policies, and resources of each program, and was administered by CCC trained volunteers in face-to-face interviews. (Appendix A). The second survey sought data relating to patient demographics, staff size, and funding sources. (Appendix B). Because this data may have required programs to consult with record-keeping or other staff, CCC mailed this survey to each program and requested the program to return it in a self-addressed stamped envelope provided by CCC. Although CCC followed-up with phone calls and letters requesting the completion of this survey, only nine programs returned the data questionnaire.

Finally, CCC staff and Task Force members worked with CCC YouthAction members to develop questions for a teen focus group (Appendix C). In March 2001, three CCC YouthAction members and two CCC staff members facilitated a focus group of ten teenagers to find out how teenagers learn about health care, their concerns about seeking health care, and their experience with health care providers in New York City. One YouthAction member orally presented the questions to the teen focus group, and the two others assisted CCC staff in facilitating and recording the discussion. The focus group participants were members of the East Side Settlement House Youth Leadership Program in the Bronx, and consisted of 6 females, and 4 males. The focus group lasted three hours, and CCC paid each participant a stipend of \$15.00. To the extent that these adolescents participate in a youth development program, their experiences and opinions may differ from adolescents who are not affiliated with similarly organized programs.

Five issues areas emerged from our analysis of the data that we gathered from site interviews and the teen focus group: (1) ensuring confidential treatment for adolescents; (2) fragmentation of services; (3) limited resources for health education and outreach; (4) the health practitioner/adolescent relationship; and (5) physical and structural barriers that make many health clinics less than adolescent-friendly. Although we recognize that many of these issues overlap, we grouped the findings and recom-

mendations presented in this report according to these five categories. We hope that this structure helps to highlight the major issues we identified and to demonstrate the need for a multi-faceted approach to providing and funding adolescent health services, and encourages policymakers and health care providers to implement changes that support a comprehensive strategy to strengthen adolescent health prevention and treatment services.

TEEN FOCUS GROUP FINDINGS AND RECOMMENDATIONS

In March 2001, three teenagers from YouthAction and two CCC staff members conducted a focus group with 10 teenagers from the Youth Leadership Program at East Side Settlement House in the Bronx. The focus group provided an opportunity for participants to inform CCC and others about the teenage experience obtaining health care in New York City, and to understand the areas teens think need improvement. In addition to responding to a series of questions developed by YouthAction members and presented by the YouthAction facilitator (Appendix C), the focus group participants offered recommendations for improving the delivery of health services to adolescents in New York City. Here's what the participants told CCC:

Most common ways teens learn about health services:

- Radio
- Friends
- School guidance counselors
- Presentations in school or community-based organizations

Clinic Environments:

- Need to be more teen friendly
- Age-appropriate magazines, health literature, music, and television shows needed in waiting rooms

Preferred Appointment Policy:

- Walk-in

Health Education:

- Teenagers don't always feel comfortable asking doctors questions and don't always get the information they need
- Teenagers want more health information
- Counseling about certain health related issues would be helpful
- More informative pamphlets or literature for teens to take with them are needed in clinics

Parental Involvement in teen health decisions or treatment:

- Depends on health issue
- Parental consent not always regarded by teens as an absolute barrier to services

Relationship with Primary Care Provider:

- Depending on health issue the gender of the health practitioner matters to most teenagers
- Ongoing relationship improves patient/provider communications
- Some teenagers doubt doctor's sincerity and interest in their individual health

Confidentiality:

- Doctors generally do not discuss confidentiality with teenagers
- Most teenagers do not know about their right to confidentiality or confidential health services

Confidentiality: A Special Concern

For many adolescents, the decision to seek health care raises concerns about confidentiality, and their ability to control who may gain access to personal information related to their diagnosis and treatment. This concern extends not only to parents, but also to peers and other significant people in an adolescent's life. In considering confidentiality, it is important to distinguish the need to obtain parental consent to access services from the protection afforded information generated by a health care visit, such as a diagnosis or medical procedures administered. Some adolescents may regard the need for parental consent as an absolute deterrent, but others may seek services with a parent's consent or involvement with an expectation that communications between himself or herself and the primary care provider will remain confidential. For example, a clinic may require parental consent in order to provide primary care to an adolescent, but the conversation between the primary care provider and adolescent should remain confidential unless the adolescent presents a danger to himself or someone else. Conversely, a clinic that allows a parent/caregiver to be present during a health related examination of an adolescent may compromise the adolescent's right to confidentiality, undermine the adolescent's ability to discuss sensitive issues with the primary care provider, and discourage the adolescent from seeking treatment in the future.

Recognizing that concerns about confidentiality may deter adolescents from seeking health care when they need it, New York State has enacted statutes that guarantee adolescents the right to obtain certain types of health services without the consent of a parent or guardian, and protect an adolescent's right to confidentiality of the health-related information by prohibiting or restricting disclosure. Some of these laws relate specifically to adolescents, while others apply to anyone obtaining the specified health service. Federal statutes and federal and state case law also provide legal authority for providing certain confidential health services to adolescents.

The Reproductive Rights Project of the New York Civil Liberties Union publishes *Teenagers, Health Care & the Law: A Guide to the Law on Minors' Rights in New York*, which provides a comprehensive explanation of the laws governing access to, and provision of, confidential health services for adolescents.¹⁴ We rely on it here to provide a

brief description of the law in New York. In general, an adolescent, with the capacity to understand the risks and benefits of the health care options presented, has the right to consent to: emergency health care, certain mental health services; certain alcohol and drug abuse services; and reproductive health care. Emancipated minors, pregnant and parenting teens, and married minors have an even broader right to consent to health services. For a more detailed explanation of an adolescent's right to confidential health services and confidentiality, please consult the *The NYCLU's Teenagers, Health Care & the Law: A Guide to the Law of Minors' Rights in New York* and applicable statutes and regulations.

The chart below summarizes the health services adolescents, with the capacity to give informed consent, may obtain without parental consent and the legal authority of these rights, and indicates whether the confidentiality of the information pertaining to the services is absolutely protected from disclosure to parents/caregivers without an adolescent's consent, or protected with certain limitations.

Finally, health care providers, managed care plans, parents/caregivers, and adolescents should be informed about the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Among other things, HIPAA establishes national standards to protect the privacy of personal health information. In December 2000, the U.S. Department of Health and Human Services promulgated the final "Privacy Rule" under HIPAA, which specifically addresses an adolescent's right to control protected health information.¹⁵ Health care providers and managed care plans governed by the Act should seek legal advice and training on its application to ensure that adolescents receive the protection the law affords them.

In addition to the protections afforded to adolescents seeking the services listed, health care providers may also invoke the *Mature Minors Doctrine* in order to provide health services to adolescents without parental consent. This doctrine recognizes that an emotionally and intellectually

14 J. Feierman, D. Lieberman, Y. Chu, *Teenagers, Health Care & the Law: A Guide to the Law of Minors' Rights in New York*, New York Civil Liberties Union, Reproductive Rights Project, p. 5.

15 OCR HIPAA Privacy TA 164.502G.001, *Parents and Minors*, Office for Civil Rights, U.S. Department of Health and Human Services, <http://www.hhs.gov/ocr/hippa/minors.html>. Although the Privacy Rule took effect in April 2001, depending on their size, health care providers and managed care plans subject to HIPAA must come into compliance with the Privacy Rule by April 2003 or April 2004. *National Standards to Protect the Privacy of Personal Health Information*, Office of Civil Rights, U.S. Department of Health and Human Services, <http://www.hhs.gov/ocr/hippa/bkgrd.html>; J. Huchenski, L. Malek, and F. L. Murtha, *Chapter 1-8, HIPAA Essentials for Effective Compliance*, CCH Healthcare Compliance Guide (2001).

Health Services That Do Not Require Consent of Parent or Guardian**Legal Authority****Scope of Confidentiality**

Emergency Health Care*

N.Y. Pub. Health Law § 2504(4)

Qualified protection

Sexually Transmitted Diseases: Testing & Treatment

N.Y. Pub. Health Law § 2305(2)

Absolute protection against disclosure to parent or guardian. Public health reporting laws require protected disclosure for certain sexually transmitted diseases.

HIV/AIDS testing and treatment

N.Y. Pub. Health Law § 2780(5)
N.Y. Pub. Health Law § 2505(4)

Absolute protection against disclosure to parent or guardian for minors able to consent; Limited protection for adolescents in foster care. Public health reporting laws permit certain disclosures to contacts and others identified in the statutes.

Contraceptive services and prescriptions

Federal case law; Social Security Act (Medicaid) and Title X of the Public Health Service Act

Absolute protection

Abortion

Federal case law

Absolute protection

Outpatient mental health counseling and treatment services*

N.Y. Mental Hyg. Law § 33.21 (c)-(d)

Qualified protection**

Outpatient substance abuse counseling and treatment*

N.Y. Mental Hyg. Law § 21.11(a)

Absolute protection

See J. Feierman, D. Lieberman, Y. Chu, *Teenagers Health Care & The Law: A Guide to the Law on Minors' Rights in New York*, New York Civil Liberties Union, Reproductive Rights Project for a detailed explanation of the applicable statutes and regulations.

* In the case of emergency care, the law establishes the circumstances that authorize a health care provider to disclose information about an adolescent's treatment to a parent/caregiver. *Ibid.* at 18 (discussing emergency care). New York law also vests health care providers with discretion to provide outpatient mental health treatment and outpatient and inpatient substance abuse treatment to adolescents without parental consent under certain circumstances. *Ibid.* at 35, 37-39.

** N.Y. Mental Hyg. Law § 33.13.

mature minor may make decisions regarding his or her own health care without parental consent or involvement. However, New York law regarding the viability and scope of this doctrine remains unsettled.¹⁶ As a result, adherence to the doctrine varies with some clinics providing primary care services to adolescents without parental consent, and others limiting confidential services to those clearly defined by statute or case law.

¹⁶ *Teenagers, Health Care & the Law*, p. 15.

Confidentiality: Findings

Not all adolescents know about their right to confidential health services. Many participants in the teen focus group lacked awareness about their rights to confidential health services and confidential communications, but expected that communications with a doctor would not be revealed to their parents/caregivers. This suggests that primary care providers may not uniformly inform their adolescent patients about their right to confidential services, the scope of the confidentiality, and the potential breaches that may occur despite precautions taken by clinics.

Most clinics interviewed relied on primary care providers to inform adolescents about confidentiality policies. All of the clinics interviewed reported that they had a policy regarding confidentiality. Eighty-six percent (n=19) of the clinics reported that a primary care provider verbally communicated the policy to an adolescent at the time of a visit and 27% (n=6) used literature to inform adolescents about the policy. In some cases, when asked about confidentiality policies, clinics referred to a written policy governing the treatment of medical records and other information by clinic employees that applied to all patients regardless of age, while others referred to the New York State laws regarding confidential services for adolescents or the NYCLU's *Teenagers, Health Care & the Law: A Guide to the Law on Minors' Rights in New York*. This inconsistency reflects the need for increased training for providers and health care staff about the laws governing confidential treatment services for adolescents, and the treatment of information emanating from a clinic visit.

Parental consent requirements among the primary care clinics varied. Seventy-three percent (n=16) of the clinics interviewed required parental consent for primary care, and 45% (n=10) of the clinics required parental consent in order to provide emergency treatment services for an adolescent. During the interviews, some clinics provided CCC with a copy of their parental consent forms. The parental consent forms used by the clinics interviewed varied. Clinics requiring parental consent typically provided parents with a general consent form the first time an adolescent obtained care. Once signed by the parent, the form allowed adolescents subsequently to obtain care on their own.

In the case of school-based health centers, the New York City Board of Education (BOE) requires all students to submit a signed parental consent form before the center may provide services to them. BOE policy also requires school-based health centers to keep the parental consent form on file. The consent form is valid throughout the adolescent's tenure at a particular school. BOE's sample consent form lists the services provided by school-based health centers, but gives the parent/caregiver the option of indicating the services to which the consent does not apply. For example, a parent/caregiver may indicate that he/she does not authorize the school-based health center to provide family planning services to his/her child, but consents to all other services listed. The form also advises parents/caregivers about the student's right to confidentiality with regard to "specific service areas in accordance with law," and that mandated health screenings, first aid

and emergency treatment, and prenatal care may be provided without parental consent.

Ten of the clinics CCC interviewed were sites of HHC. HHC sets forth its policies regarding parental consent and confidential treatment services in its *Patient Consent Policy, Procedures and Forms* manual. These policies apply to all HHC facilities, including Child Health Clinics and Communicare Clinics. The manual contains a chapter entitled, "Consent for Health Care Services for Minors," that describes HHC's general rule that parental consent must be obtained "for all procedures to be performed on minors (persons under the age of 18) . . ." ¹⁷ The chapter also identifies the services that do not under New York law and HHC policy require parental consent that are excepted from the general rule. ¹⁸ HHC's "General Consent For Minors Who Cannot Be Accompanied by a Parent/Legal Guardian," enables a parent/caregiver to consent to routine diagnostic and therapeutic procedures and medical and dental treatment, and to permit a child over age 12 to obtain these services without their presence. HHC policy also requires that the parent/caregiver submit a notarized copy of this form, unless the form is signed with an HHC employee bearing witness.

Notwithstanding the written policy, the responses among the HHC clinics interviewed to questions regarding parental consent requirements varied. The responses of the hospital-based clinics generally conformed to HHC policy. The Child Health Clinics often reported that parental consent was required for reproductive health services, which does not comport with HHC policy. Although these responses may reflect the limited knowledge of the interviewees, the responses among the Child Health Clinics were similar, which suggests the need for increased training of Child Health Clinic staff regarding HHC's parental consent and confidentiality policies for adolescents.

Not all primary care clinics interviewed adhered to New

17 Patient Consent Policy, Procedures and Forms, New York City Health and Hospitals Corporation, Chapter VI, p. 25.

18 According to HHC policy, the health services that do not require parental consent when obtained by a minor who is able to give informed consent include: emergency care, care provided when the minor is a suspected victim of child abuse/neglect, diagnosis and treatment of sexually transmitted diseases, prenatal care and delivery, gynecological examinations, the administration of contraception, abortion services, HIV testing, outpatient mental health services, and inpatient or outpatient alcohol or substance abuse treatment services. *Ibid.* at 25-36.

York State law guaranteeing adolescents the right to confidential reproductive health services. Approximately one-fifth of the clinics interviewed did not provide testing and/or treatment for sexually transmitted diseases, including HIV/AIDS, gynecological examinations, or reproductive health services without parental consent. Despite the legal right to confidential reproductive health services, a number of school-based health centers, Child Health Clinics, and a community health center reported that they did not provide reproductive health services to adolescents without parental consent.

Several clinics reported anecdotally that concerns about confidentiality lead many adolescents who have insurance to report their status as uninsured to clinics providing care. This behavior may be explained by the underlying concern shared by some adolescents that an insurance statement or bill indicates both the fact and general purpose of a visit to parents/caregivers who receive it. Even those clinics that have implemented numerous safeguards to preserve an adolescent's confidentiality have difficulty protecting against this kind of breach. In these circumstances, clinics that place priority on providing health care to adolescents are forced to absorb the cost of care provided to insured adolescents who self-declare as uninsured. This not only undermines the purpose of insurance and limits the resources available to serve uninsured adolescents, but also threatens the financial viability of clinics that lack alternate funding sources.¹⁹

Clinics attempted to follow-up on referrals, missed appointments and abnormal test results, but comprehensive adolescent specific protocols were lacking in many clinics.

Coordinating services and following-up on referrals to other providers are ways in which primary care providers strengthen relationships with patients, and improve the quality of care. Since the advent of managed care, the coordination of a patient's health care has become a key function of primary care providers and their staff. A primary care provider who regularly follows-up on referrals and treatment provided to adolescent patients by other providers may increase the likelihood that an adolescent will obtain the care needed. Without consistent and regular follow-up, an adolescent may forego needed care for which he/she was referred and fail to return to the primary care provider in the future.

Because most adolescents live under adult supervision, communicating with an adolescent after a visit poses a concern about confidentiality. All of the clinics interviewed

reported that they attempted to contact an adolescent who failed to show for a scheduled appointment or who had an abnormal test result. Many clinics interviewed by CCC have developed procedures designed to preserve an adolescent's confidentiality. In designing communication procedures, clinics must balance the responsibility to communicate with an adolescent's right to confidentiality. Some of the procedures followed by the clinics interviewed strike an appropriate balance, while others take a more flexible approach trying to use the least intrusive communication under the circumstances.

Only half of the clinics interviewed had written protocols for making referrals, and the methods of follow-up varied. More than half the clinics called the provider and/or the adolescent to confirm that the adolescent kept the appointment. Fifty-nine percent (n=13) of the clinics reported that they conducted follow-up by scheduling a subsequent appointment with the adolescent following the referral appointment. Over seventy percent of the clinics interviewed reported that telephoning and writing a letter were the most common forms of communicating with an adolescent who missed a scheduled appointment or had an abnormal test result. When leaving phone messages, several clinics reported that only a return call was requested and the purpose of the call was not revealed. Less than half of the clinics interviewed requested adolescents to provide the clinics with an alternate contact number, such as a cell phone or beeper number, or the phone number of a trusted friend where they can be contacted. Nearly one-third (32% or n=7) of the clinics reported conducting home visits if the issue was medically urgent, and other forms of communication had failed. Finally, less than a quarter of the clinics interviewed communicated with adolescents via e-mail.

Parent/Caregiver Involvement in Adolescent Health Was Encouraged by the Primary Care Clinics Interviewed. Securing parental/caregiver involvement in an adolescent's health treatment provides an opportunity to educate parents/caregivers about adolescent health issues and other resources, and is consistent with the GAPS' recommendations. Parental/caregiver involvement may also provide an adolescent with the support and understanding they need to make decisions. The teen focus group did not regard a parental consent requirement as an absolute deterrent to obtaining health services. According to the teenagers, a parental consent requirement may deter an adolescent from seeking care for "sensitive" issues. However, the concern that parental consent or involvement may deter some adolescents from seeking health care

¹⁹ Adolescent Health Services: Improving Health & Lower Health Care Costs, Evidence from the Mount Sinai Adolescent Health Center. (May 2001).

must be weighed against the parental interest in, and responsibility for, their adolescent's health and well-being.

Almost all of the clinics (86% n=19) interviewed encouraged the participation of parents/caregivers in the health treatment of adolescents. Several clinics encouraged but did not require the involvement of a parent/caregiver. Other clinics required parental involvement, but preserved an adolescent's confidentiality by meeting with adolescents and parents/caregivers separately. And, some providers met jointly with parents/caregivers and adolescents to discuss the confidentiality policy, but the primary care provider met separately with the adolescent when conducting an examination. Whatever the approach, it is essential for primary care providers and health care staff to help adolescents consider the potential consequences, positive or negative, of involving a parent/caregiver in his or her treatment. Any contact made by a primary care provider or health care staff with a parent/caregiver should not occur without an adolescent's knowledge, consent, and participation.

Confidentiality: Recommendations

According to CCC's findings, inconsistent knowledge and understanding of the legal rights of adolescents to confidential health services exists among New York City adolescents and health care providers. In addition, many clinics lacked written protocols for informing adolescents about parental consent requirements and confidentiality, or for preserving an adolescent's confidentiality when attempting to contact an adolescent following an appointment. To increase awareness of the legal rights of adolescents, to encourage uniform adherence to laws governing confidentiality and parental consent, and to facilitate communication with adolescents who access care, CCC recommends that:

- The NYS DOH should require, as a condition of licensure, that health care providers serving adolescents display their confidentiality policy in public areas, such as a waiting room, and provide adolescent patients with a written description of the policy that governs the protection and disclosure of all verbal and written communications emanating from a health care visit, and the limitations of the policies in guarding against potential breaches in confidentiality.
- The NYC DPH should provide the New York Civil Liberties Union (NYCLU) with funding to reproduce *Teenagers, Health Care & the Law: A Guide to the Law on Minors' Rights in New York* for distribution to all primary care providers serving adolescents, high schools throughout

New York City, youth programs, community centers and other community-based settings frequented by adolescents. The NYC DPH should also work with the NYCLU and the health care provider community to develop a strategy for comprehensive distribution of the Guide.

- The NYS DOH should develop adolescent specific protocols and policies that: (1) specify the health services an adolescent may obtain without parental consent; (2) set forth requirements for informing adolescents about their right to confidential health services, and (3) describe the methods for communicating with adolescents following an appointment, examination, or referral. The NYS DOH should mandate that managed care plans and their providers implement these protocols, and require the Office of Medicaid Managed Care to conduct oversight to ensure compliance.
- HHC should increase training for its staff, including Child Health Clinic staff, about the policies governing parental consent and confidential health services for adolescents.

Limited Health Service Options for Adolescents

The clinics interviewed by CCC reported that the most common health reasons for adolescent visits to their clinics included: reproductive health issues, routine physicals, and chronic health conditions. Clinics also identified mental health issues as regularly presented by adolescents. According to the clinics interviewed, mental health problems frequently presented by adolescents were depression, relationship conflicts, suicidal ideation, and school-related problems. Because very few health clinics in New York City offer adolescents a comprehensive array of health and mental health services under a single roof, an adolescent may be forced to go to one place for primary care, another for mental health services, and even another place for dental or substance abuse services. This fragmentation challenges even the most resourceful adolescent, and increases the risk that adolescents will forego needed care. For example, a visit to a primary care provider at a school-based health center may indicate a need for mental health services. The school-based health center may be equipped to assess an adolescent's mental health status and need for treatment, but may not provide ongoing mental health treatment services and refer the adolescent to a mental health clinic in the community. Although the school-based health center may follow-up on the referral, it is typically incumbent upon the adolescent to go to the mental health clinic appointment.

Health Insurance for Adolescents

Although health insurance does not guarantee access to care, enrolling in insurance removes a significant obstacle to obtaining care – the inability to pay for health services. For adolescents, research shows that health insurance increases the likelihood of health care access and utilization, and that an adolescent will have a regular source of care, and have fewer unmet health needs.²⁰ In addition, insured adolescents are less likely to forego health care than those without insurance.²¹

The uninsurance rate among adolescents is higher than that for most other minors.²² In one study analyzing 1995 data, researchers found that “adolescents living in families with incomes less than 200% of the Federal Poverty Level are six times more likely to be uninsured than adolescent in more affluent families.”²³ Adolescents living in poverty in New York City are similarly situated. In 1998, for example, almost 35% of the Child Health Plus A (Medicaid) eligible adolescents aged 15-21 were not enrolled in 1998.²⁴

Adolescents up to age 19 in New York State are eligible for one of two public health insurance programs, Child Health Plus A (formerly known as Medicaid) or Child Health Plus B. Each of these programs offers comprehensive health care coverage, but the age and income eligibility requirements for each program vary. For Child Health Plus A, an adolescent is eligible for enrollment up to the age of 18. In September 2001, New York State obtained federal approval to expand income eligibility for Child Health Plus A for 6-18 year olds from 100% of the Federal Poverty Level (FPL) (\$17,652 per year for a family of four) to 133% of the FPL (\$23,484 per year for a family of four).²⁵ This expansion is scheduled to take effect April 1, 2002. In federal fiscal year 2000, 299,725 New York City adolescents were enrolled in Child Health Plus A.²⁶

Adolescents who exceed income eligibility requirements for Child Health Plus A, may enroll in Child Health Plus B until their 19th birthday, and family income determines the cost of the premium to be paid. Families with incomes up to 160% of the FPL (\$28,240 per year for a family of four) pay no premium, families with incomes between 160%-222% of the FPL (\$28,416- \$38,830 per year per family) pay \$9 per month per child up to a monthly maximum of \$27, and families with incomes between 222% and 250% of the FPL (\$38,830-\$44,125 per year for a family of four) pay \$15 a month per child up to a monthly maximum of \$45. Although originally created in 1991 to provide health insurance for children up to age 13, New York State expanded eligibility to adolescents in 1997. As of December 2000, there were 138,600 New York City adolescents ages 11-19 enrolled in Child Health Plus B.

20 P. Newacheck, C. Brindis, C. Cart, K. Marchi, and C. Irwin, *Adolescent Health Insurance Coverage: Recent Changes and Access to Care*, Pediatrics. 1999; 104:199.

21 J. Klein, K. Wilson, M. McNulty, C. Kappahin, K. Collins, *Access to Medical Care for Adolescents: Results from the 1997 Commonwealth Fund Survey of the Health of Adolescent Girls*, J. Adolesc. Health. 1999; 25: 120-130.

22 New York State Maternal Child Health Services Title V Block Grant, 2000 Annual Report/2002 Application, p. 80.

23 P. Newacheck, C. Brindis, C. Cart, K. Marchi, and C. Irwin, *Adolescent Health Insurance Coverage: Recent Changes and Access to Care*, Pediatrics. 1999; 104: 199.

24 K. Thorpe and C. Florence, *Medicaid Eligible, But Uninsured, the New York State Experience*, A Working Paper, United Hospital Fund (October 2000), p. 3.

25 Revised Medical Financial Levels for 2001, New York City/Human Resources Administration/Medical Assistance Programs/Eligibility Information Services (April 3, 2001); *HHS Approves New York Plan to Extend Medicaid Coverage to Include More Children Without Health Insurance*, HHS News, U.S. Department of Health and Human Services, (September 15, 2001).

26 DOH/OMM Audit, Fiscal Program and Planning Data Mart.

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Notwithstanding the availability of public health insurance for adolescents, barriers to their enrollment continue to exist. This is particularly true for adolescents who age out of foster care or leave the juvenile justice system. For example, the lack of uniform eligibility requirements between Child Health Plus A and Child Health Plus B creates the possibility for a gap in coverage for 18 year old adolescents whose income exceeds adult Medicaid eligibility requirements. In these circumstances, an 18 year old would be eligible to enroll in Child Health Plus B for one year, assuming the adolescent could negotiate the enrollment process. In previous studies, CCC learned that this is particularly problematic for adolescents aging out of foster care or leaving juvenile detention. In 1999, Congress enacted the Foster Care Independence Act to remedy this problem for adolescents leaving foster care by allowing States the option of extending their Medicaid coverage up to the age of 21. To date, New York State has not exercised this option. CCC encourages the Governor and the New York State Legislature to provide Child Health Plus A coverage to the youth aging out of foster care up to the 21st birthday in accordance with the Foster Care Independence Act.

Another significant barrier is that with limited exceptions, adolescents cannot enroll in Child Health Plus A or B without parental involvement. In New York State, adolescent health care advocates are seeking legislation that would allow adolescents up to age 21 to apply on their own for limited confidential Medicaid coverage without regard to family income. This proposed coverage would be confidential and extend only to those services adolescents are now entitled by law to receive without parental consent.²⁷ Uninsured adolescents and adolescents enrolled in Medicaid Managed Care and Child Health Plus B who participated in plans that foreclosed access to adolescent health services of the adolescents' choice would be eligible for the limited coverage under this proposal as well.²⁸ CCC recommends that the Governor and New York State Legislature support this proposal by expanding Child Health Plus A to cover adolescents up to age 21 for health and mental health services they can obtain without parental consent under New York and federal law, and allow adolescents confidentially to self-enroll without regard to parental income or resources.

27 Adolescent Access to Health Care Services: A Proposal to Ensure Medicaid Coverage of Essential Care, presented by Angela Diaz, M.D., Mount Sinai Adolescent Health Center (May 2001) p. 2.

28 Ibid.

Health Service Options: Findings

Lack of on-site mental health and dental services forced many primary care clinics to refer adolescents to community-based services. All of the clinics CCC interviewed provided an array of primary and preventive care to adolescents, including routine check-ups, school/activity examinations, immunizations, diagnosis and treatment of acute illness, hearing and vision screening, and screening and assessing for mental health problems. However, many interviewees expressed concern over the lack of mental health services within their clinics and in the community. Eighty-two percent (n=18) of the clinics interviewed referred adolescents to mental health services provided by a hospital-based psychiatric department or community-based mental health clinic. Seventy-seven percent (n=17) of the clinics referred adolescents for community-based dental services.

Comprehensive reproductive health services were not uniformly provided as part of routine primary and preventive adolescent health care. For many teenagers, adolescence marks the beginning of sexual activity and exploration. In 1999, thirty percent of New York State high school

students reported being sexually active, and six percent of the students reported engaging in sexual intercourse before age 13.²⁹ Sexually active behavior may have serious health implications for adolescents. According to the Center for Disease Control and Prevention, "adolescents are at a higher risk [than adults] for acquiring STDs: they are more likely to have multiple sexual partners and short-term relationships, to engage in unprotected intercourse, and to have partners who are themselves at high risk for STDs."³⁰ In recognition of these risks, the GAPS devote almost a quarter of its recommendations to screening and detecting reproductive health problems.

Basic reproductive health services include screening and treatment for sexually transmitted diseases, gynecological

29 New York State, Maternal and Child Health Services, Title V Block Grant Program, 2000 Annual Report/2002 Application, p. 97 (citing New York State Youth Risk Behavior Survey).

30 Health, United States, 2000 with Adolescent Health Chartbook, U.S. Department of Health and Human Services, Center for Disease Control and Prevention, (July 2000), p. 70.

examinations for adolescent females, pregnancy testing and options counseling, pregnancy termination, and distribution or prescription of contraceptive methods. Child Health Plus A (Medicaid) and Child Health Plus B guarantee enrolled adolescents insurance coverage for a full range of reproductive health services.³¹ These insurance programs cover: contraception, emergency contraception, medically necessary abortions, sexually transmitted diseases screening, diagnosis, and treatment, HIV testing and treatment, and screening for pregnancy. Although New York State law guarantees free access to these services, managed care plans are not required to provide reproductive health coverage under Child Health Plus A and Child Health Plus B. Adolescents enrolled in Medicaid Managed Care may obtain reproductive services from any qualified Medicaid provider, regardless of whether the provider is part of the managed care plan's network.³² Unlike Child Health Plus A (Medicaid) enrollees, an adolescent enrolled in Child Health Plus B has a limited choice of reproductive health care providers. For adolescents enrolled in managed care plans under Child Health Plus B that do not provide comprehensive reproductive services, the managed care plan must contract with a provider of reproductive health services and refer adolescents to the provider under contract with the managed care plan for services.³³

Eighty-two percent (n=18) of the clinics interviewed by CCC had equipment to conduct gynecological examinations for adolescent girls, but not all clinics provided reproductive health services on-site. In some cases, hospital-based pediatric clinics referred girls to community-based family planning services to ensure their confidentiality or to the hospital's adult department of obstetrics and gynecology. The availability of gynecological equipment and other reproductive health services at the Child Health Clinics varied, with only half the Child Health Clinics interviewed reporting that they conducted gynecological examinations.

Most adolescent clinics interviewed offered pregnancy testing and counseling, HIV/AIDS testing and counseling, and testing for sexually transmitted diseases. Unsafe sex leaves adolescents at risk of becoming pregnant, and contracting sexually transmitted diseases, including HIV/AIDS. Despite the recent decline in teenage birth rates in New York City,³⁴ large numbers of sexually active adolescents continue to contract sexually transmitted diseases, such as chlamydia and gonorrhea. In 1996, adolescents (aged 19 years and younger) comprised 41% of chlamydia cases and 28% of gonorrhea cases reported in New York City.³⁵ In 2000, New York State directed Maternal Child Block State Block Grant funds to family planning sites to operate the Chlamydia Testing Program.³⁶ Although curable, without treatment chlamydia and other sexually transmitted diseases may lead to long term health problems, such as pelvic inflammatory disease, chronic pain, and infertility.³⁷ In an effort to prevent, detect, and treat health risks resulting from sexual activity, over 85% of the clinics interviewed reported that they provided pregnancy testing and counseling, HIV/AIDS testing and counseling, and testing for sexually transmitted diseases.

Not all clinics interviewed distributed contraception to adolescents. Sixty-eight percent (n=15) of the clinics reported that they distributed condoms, and only slightly more than half (54.5% (n=12)) distributed oral contraception to adolescents. Some of the clinics that did not distribute contraception on-site provided adolescent girls with a prescription for oral contraception or referred them to an adult department of obstetrics and gynecology or a community-based family planning clinic for contraception and other reproductive health needs.

School-based health centers reportedly had more restrictive contraception policies than other clinics interviewed. New York City Board of Education (BOE) policy prohibits school-based health centers from distributing contraception on school premises. The BOE's Expanded

31 *State-by-State Profiles: New York*, <http://medicaidmanagedcare.naralny.org/states/ny.htm> quoting The Partnership Plan: Operational Protocol (July 1997) at 7-1; *Child Health Plus and Reproductive Health Benefits Pamphlet*, New York Forum for Child Health, New York Civil Liberties Union Reproductive Rights Project, Planned Parenthood of New York City, Inc. (May 2001).

32 <http://www.medicicaidmanagedcare.naralny.org/states/ny.html> quoting the Partnership Plan: Operational Protocol (July 1997) at 7-3 and citing N.Y. Soc. Serv. L. §364-j (4)(a)(iii)(C) (McKinney 1998).

33 *Child Health Plus and Reproductive Health Benefits Pamphlet*, New York Forum for Child Health, New York Civil Liberties Union, and Planned Parenthood of New York City, Inc. (May 2001).

34 *Keeping Track of New York City's Children*, Citizens' Committee for Children of New York, Inc. (2000), p. 102.

35 *Summary of Reportable Diseases and Conditions, 1996*, City Health Information, New York City Department of Health, Vol. 17, No. 1, p. 14 (June 1998).

36 *New York State, Maternal and Child Health Services, Title V Block Grant Program, 2000 Annual Report/2002 Application*, p. 59.

37 *Health, United States, 2000 with Adolescent Health Chartbook*, United States Department of Health and Human Services, Centers for Disease Control and Prevention (July 2000), p. 70.

HIV/AIDS Education Program creates an exception to this rule and allows school-based health centers and resource rooms in New York City public high schools to make condoms available in response to the AIDS epidemic. The NYC DPH's School Health Program supplies condoms to public schools. However, parental consent forms give parents the option of withholding their consent with respect to this health service.

The four Child Health Clinics and one Communicable Disease Clinic interviewed reported that they did not distribute condoms or contraception to adolescent patients. One interviewee attributed this to the fact that Child Health Clinics do not receive federal family planning services under Title X.

Adolescents are likely to encounter difficulty obtaining medication. Almost half of the clinics interviewed had a pharmacy on-site, and 91% (n=20) prescribed medication for adolescents. Although pharmacies located on health care premises provide a convenience for any patient, the cost of the medication may preclude adolescents from obtaining it. All "medically necessary" prescriptions, including contraceptive medication or devices, are covered insurance benefits under Child Health Plus A (Medicaid) and Child Health Plus B. Nevertheless, concerns about confidentiality may deter adolescents enrolled in these insurance programs from availing themselves of this benefit.

Health Service Options: Recommendations

CCC findings show that health and mental health services in New York City are fragmented, and that the range of services available to an adolescent varies by clinic. These circumstances force adolescents to learn about where to go for particular kinds of care through trial and error or vicariously through the trial and error experiences of their peers. For adolescents who may be hesitant to obtain care or become frustrated with the task of negotiating a complex system of care the decision to forego care may become more appealing. In addition, the variation among clinics in the types of the services provided increases the risk that health problems may go undetected and/or that the health education acquired by an adolescent during a visit will be limited. This is particularly problematic in areas, such as reproductive health, for which adolescents remain at high risk of developing health conditions that affect their short and long-term health. In an effort to decrease fragmentation, strengthen linkages between services, and improve the comprehensiveness of the care provided to adolescents, CCC recommends that:

- HHC and voluntary hospitals should explore the possibility of co-locating services for adolescents on a single floor or single building. Co-location of services in a single location would improve adolescent access to a full range of services. Although many hospitals may offer an array of services within a single location, navigating the multiple floors, buildings, and wings of a hospital presents a challenge to health care consumers and staff alike.
- HHC and voluntary hospitals should, as one interviewee suggested, create "Adolescent Liaison" positions. The job responsibilities of an Adolescent Liaison would include escorting adolescents to appointments within different hospital locations, following through with adolescents referred to services located in the community, and establishing linkages to community-based services and other health care providers, such as school-based health centers, Child Health Clinics, and Community Health Centers. The relationship between the Adolescent Liaison and an adolescent also provides an opportunity for an adolescent to learn how to navigate a complicated health care system, skills that would prove beneficial to adolescents when they become adults.
- The NYC DPH in conjunction with HHC, the local chapters of the American Academy of Pediatrics, the Coalition of Voluntary Mental Health Agencies, the Community Health Care Association, the Coalition for School-Based Primary Care, the Alcohol and Substance Abuse Provider Association, and the New York City chapter of the American Dental Association should develop linkage partnerships between primary care providers and community-based mental health and substance abuse providers, and dentists. The linkage partnerships would enable providers to establish relationships, increase their knowledge of available services, and facilitate referrals of adolescents to appropriate services in their communities.
- The New York State Office of Mental Health and the NYS DOH should lift the Medicaid Neutrality Cap, and expand community-based outpatient mental health services to settings, such as schools, school-based health centers, Child Health Clinics, homes, and community centers.
- HHC should require all Child Health Clinics to conduct gynecological examinations and screen adolescent boys and girls for sexually transmitted diseases or to link adolescent patients to an HHC network provider to obtain these and other reproductive health services.

- NYC DPH should work with HHC to develop a condom availability program for Child Health Clinics and Communicare Clinics.
- Voluntary and public hospital-based clinics should create adolescent clinic hours within the adult department of gynecology and obstetrics, or require gynecologists to provide services to adolescents in hospital-based or affiliated pediatric or adolescent clinics during hours designated for adolescents only.
- HHC should provide medication at no cost to adolescents who obtain a prescription from an outpatient clinic or Child Health Clinic, and seek retroactive confidential reimbursement from Child Health Plus A and Child Health Plus B.

Health Education: A Critical Line of Defense

As the GAPS suggest health education is essential to promoting adolescent health and safety. Whether provided verbally by a health care provider, or through literature or the media, health education helps an adolescent understand what to expect upon seeking care, to prepare to accept the results of an examination, and to understand the available treatment options. It also equips adolescents with the knowledge to assess potential risks to their health and safety when making behavioral decisions. The NYC DPH makes health education literature available to schools and community-based organizations, provides technical assistance about health issues to community-based and other organizations serving adolescents, and conducts on-site educational workshops in public high schools and some intermediate schools. Like many health care providers and organizations, the NYC DPH purchases many health education materials from private companies.

The teen focus group shared several opinions about health education. First, and most importantly, they expressed frustration with the limited breadth and depth of the information available. Specifically, the teenagers reported that they often find the materials now available to be lacking in sufficient substance, and expressed an interest in having more comprehensive information published and available. In addition, the teenagers suggested that health care providers make more written materials about common health problems available to adolescent patients. The group explained that health education materials help to provide answers to questions that they may have felt uncomfortable asking their health care provider or clarify information that they did not understand.

Health Education: Findings

Health education was most often conveyed verbally by primary care providers to adolescents, but some clinics used innovative ways to educate adolescents about health issues. All clinics interviewed reported that they provided health education to adolescent patients, and 91% (n=20) reported that primary care providers conveyed the information verbally to adolescents during an examination. The heavy reliance on verbal communication to convey health education underscores the importance of the doctor/patient relationship. Thirty-six percent (n=8) of the clinics reported that they also provided health education materials, including literature and videotapes, on the program premises. Another clinic reported that it loaned adolescent patients health education videos to watch at home.

The teen focus group cited presentations by health care providers in school or community-based organizations as sources of health information and resources. Public presentations provide an opportunity to educate adolescents about health risks and treatments, and to inform adolescents about where to go to obtain care. Fifty percent (n=11) of the clinics interviewed reported that they provided health related presentations in schools, 45% (n=10) provided presentations in community-based organizations, and two clinics conducted health related presentations in juvenile detention facilities. In addition to presentations, 68% (n=15) of the clinics interviewed distributed fliers to inform adolescents and others about the services they provided.

Because not all adolescents establish regular and ongoing relationships with a primary care provider, the need for other sources of health education is evident. The teen focus group informed CCC that many teenagers learn about health services over the radio. In this computer-based information age, the Internet also acts as a regular source of information for adolescents. Five clinics reported that they maintain or are developing a website. Computers with Internet access are available in public schools and libraries throughout New York City. As a result, health websites would serve a valuable function in providing health information, links, and referral information to adolescents, and eliminate potential embarrassment adolescents may experience in seeking information during a face-to-face encounter with a health professional.

Few clinics engaged youth in health-promoting education activities. Adolescents often turn to peers before anyone else for information, advice, and support. Youth development programs throughout the country have recognized the value

of peer relationships in effecting positive outcomes for youth. Many health prevention programs that yield positive outcomes offer adolescents psycho-educational and/counseling in peer groups,³⁸ and others engage youth as leaders to educate their peers about pertinent issues.

Although peer education programs offer an opportunity to formalize this method of outreach and provide adolescents serving as peer educators with knowledge about health related issues to teach to their peers, less than one-third (32% (n=7)) of the clinics interviewed had peer education programs. One of the clinics interviewed provided a model peer education program that trained peer educators in health issues, cultural sensitivity, and outreach, and paid them. In this regard peer education programs, function as youth leadership programs, job training programs, and expose adolescents to careers possibilities in public health, medicine, and education. Other peer education programs enabled peer educators to earn school credit or community service hours.

Health Education: Recommendations

CCC's findings demonstrate that many clinics attempt to educate adolescents about health risks and their own development, but limited resources force them to rely heavily on primary care providers to convey essential information. To improve the breadth of health education for adolescents and to enhance the health education and outreach efforts of primary care clinics, CCC recommends that:

- The NYC DPH should launch a multi-faceted adolescent health education campaign that provides comprehensive information for adolescents about prevalent health related issues or conditions and where to go for health and mental health services. The NYC DPH should also create an advisory committee comprised of adolescent health specialists, and representatives of HHC and its Child Health Clinics, the Greater New York Hospital Association, and the American Academy of Pediatrics to help design the campaign and develop strategies for its implementation. The advisory committee should also invite teenage participation. The health education campaign should also include an expansion of NYC DPH's website to include information on adolescent health issues, create

a link to the HealthStat Directory, and list other community-based services available to adolescents. The NYC DPH should explore partnership opportunities with foundations and corporations to help fund public service announcements and advertisements for health resources, publication and dissemination of literature to adolescents, and other efforts.

- The NYC DPH should create and distribute to all schools, community-based organizations, and faith-based organizations a comprehensive directory of adolescent health services. NYC DPH should also revise the HealthStat directory to indicate providers with training and certification in adolescent medicine.
- The NYC DPH should establish a help-line for adolescents to call to obtain counseling and referrals to health services. The telephone number for the help-line should be posted on the NYC DPH website and be included in advertisements published as part of the education campaign.
- HHC should provide Child Health Clinics with funding to conduct outreach and education to adolescents in their communities.
- The NYC DPH with financial participation by the NYS DOH should fund a peer health education program for New York City youth.

The Practitioner/Adolescent Relationship: The Crucial Link

The practice of assigning a primary care provider to adolescents creates the potential to build a trusting relationship, and likely improves the health treatment and education interventions. Because adolescents may find it difficult to discuss questions related to their health and development, a primary care provider's ability to relate to an adolescent with respect and interest may enhance the effectiveness of a health intervention. By providing open, consistent, and ongoing care, primary care providers and health clinic staff may build strong relationships with adolescents who seek care. Each encounter offers the opportunity to examine an adolescent's immediate health condition, to screen for other health and mental health risks, to provide health education that may help an adolescent assess health risks of future behavior, and to encourage the adolescent to become a smart health care consumer. The teen focus group agreed that an ongoing relationship with a primary care provider facilitates communication, particularly about sensitive topics, and encourages them to return for care.

38 M. Eisen, C. Pallitto, C. Bradner, and N. Bolshun, *Teen Risk-Taking: Promising Prevention Programs and Approaches*, Urban Institute (September 2000).

Too Few Adolescent Medicine Specialists

Family practitioners, internists, and pediatricians may become board certified in adolescent medicine. Specialization in adolescent medicine requires three years of training in adolescent medicine, and passing a certification exam. However, the supply of adolescent specialists is limited. As of January 2001, there were a total of 440 board certified adolescent specialists nationwide.³⁹ Residency programs in family practice, pediatrics, and internal medicine also require training in adolescent medicine.

Practitioner/Adolescent Relationship: Findings

Almost all the clinics interviewed assigned a primary care provider to adolescents. Ninety-one percent (n=20) of clinics interviewed reported that at the first visit an adolescent was assigned to a primary care provider, and that at more than three-quarters of the clinics (77% n=17) an adolescent was "likely" or "very likely" to be seen by his or her assigned provider.

Inadequate reimbursement rates force clinics to absorb cost of quality adolescent health care. The GAPS recommendations emphasize the critical need to provide health education and screening to adolescents, particularly in areas that threaten their morbidity and mortality. Effective implementation of such recommendations is furthered by an ongoing provider/patient relationship, and adequate time to screen for potential problems, and convey information related to the diagnosis, treatment, and prevention.

Seventy-three percent (n=16) of the clinics interviewed by CCC reported that primary care providers spend more than 30 minutes with an adolescent during an initial visit, and 95% (n=21) of the clinics made primary care providers available by telephone 24 hours/day for follow-up calls by adolescent patients. However, throughout the interviews, CCC was repeatedly informed that managed care reimbursement mechanisms do not adequately cover the cost of adolescent health care visits. As a result, clinics dedicated to providing the best possible health interventions to adolescents are forced to suffer adverse financial conse-

quences, which threaten their ability to continue providing services.⁴⁰

Some members of the teen focus group reported experiencing primary care providers as asking only questions they are required to ask and hurrying through an appointment or examination. This behavior caused the adolescents to question the providers' interest in understanding and treating their problems. It is possible time pressures placed on primary care providers striving to meet managed care targets leave inadequate time to engage adolescents and to discuss more sensitive and perhaps more serious health concerns, and may partially explain the experience reported by the teenagers in the focus group.

Recognizing the importance of obtaining an accurate and complete description of an adolescent's health status, history, and concerns, and the limited time available to primary care providers, 91% (n=20) of the clinics interviewed required adolescents to meet with other health care staff during an initial visit. For example, half (n=11) of the clinics reported that teenagers met with a health educator, social worker, or nutritionist who provided counseling or anticipatory guidance regarding health related topics. This comprehensive approach to health education and screening likely enhances the quality of information provided by, and received by, the adolescent and enables health care providers to make appropriate interventions.

Primary care providers and other health care staff need more training on adolescent development, health, and engagement. The encounters with all staff at a health clinic influence an adolescent's comfort level in seeking treatment and sharing important health information and concerns. Often, the responsibility for setting the stage for a positive interaction lies with the staff, beginning with the receptionist and including all staff with whom the adolescent comes into contact during an appointment. Knowledgeable staff help to reduce the anxiety, fears, and concerns experienced by an adolescent by asking appropriate questions and providing helpful information.

Forty-one percent (n=9) of the clinics reported that physicians conducted follow-up on referrals. In addition to physicians, the clinics reported that other health care staff, including nurses, nurse practitioners, physician assistants, health educators, and social workers conducted follow-up, assessments, and screenings of adolescents. However, less

39 American Board of Pediatrics, www.abp.org/STATS/numdips.htm; American Board of Internal Medicine, www.Abim.org/info/states.htm. In November 2001, the American Board of Family Practice will administer the first examination for earning a certificate in adolescent medicine.

40 Adolescent Health Services: Improving Health & Lowering Health Care Costs, Evidence from the Mount Sinai Adolescent Health Center (May 2001).

than two-thirds (n=14) of the clinics interviewed provided training for staff on adolescent related issues, and 41% (n=9) reported that they provided the training on-site. Limited training means that most staff, including primary care providers, develops their expertise on-the-job. Anecdotally CCC learned that staff and program directors want more training on adolescent development and common adolescent health problems.

New efforts are underway to respond to the need for increased training in adolescent health and to improve the quality of adolescent health services. In 1999, HHC surveyed employees to learn in what areas they wanted to receive training. Due to an overwhelming response identifying the need for training in adolescent health, HHC convened the first annual training conference on adolescent health in May 2000. The success of this conference resulted in the creation of the HHC Adolescent Health Initiative. HHC convened the second annual adolescent health training in May 2001, and has plans to hold its third conference in 2002. In 2000, the NYS DOH similarly recognized the need to improve the access and quality of preventive health services for adolescents, and created the *Medicaid Managed Care Provider Grants: Collaborative Initiatives to Improve Access to Preventive Health Care for Adolescents*. Under this initiative, the NYS DOH awarded one-year grants to three providers of adolescent health services to partner with managed care plans and/or community-based organizations to improve the quality and delivery of adolescent health services. Two of the grantees are located in New York City. Finally, the New York Chapter III of the American Academy of Pediatrics recognized the need for increased training in adolescent health and convened a one-day continuing education conference for its members in October 2001.

Practitioner/Adolescent Relationship: Recommendations

To improve effective communication with adolescent health care consumers, increase the likelihood that adolescents will seek health care when they need it, and to promote comprehensive primary and preventive health treatment by professionals trained in adolescent health and development, CCC recommends that:

- The NYS DOH should build on the work of the Medicaid Managed Care Provider Grantees and create a comprehensive statewide Adolescent Health Services Initiative that establishes a long-range plan for improving access, organization, and delivery of adolescent health services. This initiative should include the development of adolescent-specific protocols governing

confidentiality, conducting health screening and detection for health conditions prevalent among adolescents, and the establishment of adolescent health training curriculum and materials for dissemination to managed care plans and primary care clinics.

- The NYS DOH should require managed care plans that contract with New York State to provide health services to adolescents enrolled in Child Health Plus A and Child Health Plus B to conduct mandatory training in adolescent health for primary care and other health providers affiliated with the plans.
- The NYS DOH should extend and expand the Medicaid Managed Care Provider Grantee grants to enable grantees to provide technical assistance to other managed care plans and community-based provider organizations in New York City in developing trainings, screening and diagnostic tools, and adolescent-specific protocols. The grantees should also act as an advisory group to the NYS DOH in developing a statewide Adolescent Health Services Initiative.
- The NYS DOH should assess the adequacy of current insurance reimbursement levels for Child Health Plus A and Child Health Plus B, and explore the possibility of developing a unique reimbursement rate for initial adolescent health consultations.

Need For Adolescent-Friendly Health Care Environments

With few exceptions, adolescents comprised a subset of the patients served by the clinics interviewed by CCC. For example, hospital-based outpatient clinics located in departments of pediatrics typically serve children and adolescents ages 0-18, and community health centers serve children, adolescents, and adults. The teen focus group expressed a preference for clinic environments that acknowledged their interests and unique health needs. That only 41% (n=9) of the clinics provided patient satisfaction surveys to adolescent patients and even fewer used suggestion boxes or verbal feedback to gauge adolescent opinion indicate the need for clinics to take adolescents into account when making decisions regarding space allocation, clinic hours, décor, and selection of health education materials. The teen focus group recommended that furnishing waiting rooms with age-appropriate furniture, magazines, and health related literature, and playing music and television shows aimed at adolescents would help to make adolescents feel welcome and encourage them to return for care.

Health Care Environments: Findings

Clinics hours attempted to accommodate adolescent schedules, but the number of adolescent-only clinic hours and clinic space were limited in the clinics interviewed. The availability of early morning, after-school, and evening hours minimize possible disruption in an adolescent's school day, and also accommodates the schedules of working adolescents and parents/caregivers who may accompany an adolescent to an appointment. Seventy-three percent (n=16) of clinics interviewed reported that hours of operation began before 9:00am at least one day per week, 68% (n=15) of the clinics provided care after 4:00pm, and 32% (n=7) of the clinics provided care on weekends. In many cases, clinics offered extended evening hours once or twice a week. For example, a clinic may have evening hours on Tuesday and Thursday evenings.

Some clinics dedicated certain hours each week to serving adolescents only. Hospitals refer to these hours as an "adolescent clinic." The structures of adolescent clinics may vary. For example, different rules regarding fees and parental consent may apply when an adolescent seeks care from the adolescent clinic rather than through the department of pediatrics during regular hours. In addition, an adolescent clinic may be staffed with a primary care provider board certified as an adolescent specialist, or a physician in training for certification. Thus, apart from the actual hours of operation, clinics may encourage adolescents to seek care by offering hours dedicated only to their care. An adolescent seeking care during these hours may not only have the advantage of seeing an adolescent specialist, but will also encounter mostly peers in the waiting room and other clinic areas. Less than two-thirds (59% or n=13) of the clinics interviewed had hours dedicated specifically to serving adolescents, and 32% (n=7) reported devoting more than 32 hours per week to adolescent clinics.

Only half the clinics interviewed had space devoted exclusively to adolescents. Although some clinics may reserve certain examinations rooms for adolescents, the rooms are often located immediately next to the rooms used for younger children and their parents/caregivers. Of the clinics interviewed, only half had space devoted specifically to adolescents. The presence of age appropriate furniture materials for adolescents in waiting and examination rooms helps to increase their comfort level. In the absence of these and other accommodations, adolescents may not feel comfortable, and be deterred from returning for care.

Most clinics offered appointments on a walk-in basis for adolescents. The teen focus group expressed a strong preference for walk-in rather than scheduled appointments. The teenagers explained that the decision to seek health care may be difficult for many adolescents who fear a health examination or its results. Walk-in appointments provide adolescents with the flexibility to seek health care immediately and guard against the possibility that an adolescent may decide not to seek care during the interval between making an appointment and the actual appointment date. Eighty-six percent (n=19) of the clinics interviewed accommodated adolescents by offering a walk-in appointment policy, and 82% (n=18) reported that staff performs triage to determine the level of intervention required. CCC did not ascertain whether adolescents who present non-emergent conditions at a walk-in appointment will be provided with care immediately or be given a scheduled appointment for another day.

Fees may limit adolescents from seeking care at some of the clinics interviewed. All of the clinics interviewed reported that they provided care to uninsured adolescents, but more than a quarter charged a fee for services provided. Twenty-seven percent (n=6) of the clinics interviewed indicated that they used a sliding payment scale for uninsured adolescents. In the case of one clinic, the scale ranged from \$0-\$60. Two community health centers maintained a \$25 fee per visit, and a third clinic established a payment plan for patients unable to pay at the time services are rendered. Because few adolescents have disposable income, imposition of any fees may act as an absolute deterrent to seeking care when they need it and may increase the likelihood that they will ultimately seek care in a hospital emergency room if their health condition worsens. In the absence of fees, adolescents are more likely to obtain the primary care needed, and avert the need for emergency room care, a costly alternative.

In October 2001, HHC extended the Child Health Clinic policy of serving all children and adolescents under the age of 18 regardless of ability to pay to all HHC clinics. As a result, teenagers may now seek care at HHC outpatient hospital clinics, diagnostic and treatment centers, and satellite clinics free of charge. For those adolescents who identify themselves as insured, HHC will seek reimbursement for services rendered.

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Transportation Assistance Is Not Always Provided to Adolescents Seeking Care.

Ninety-five percent (n=21) of the clinics interviewed were located within seven blocks of a subway station or bus stop. Despite proximity to public transportation, an inability to pay for transportation to and from the clinics may prevent adolescents from accessing care. Fifty-five percent (n=12) of the clinics interviewed reported that they did not provide transportation assistance to adolescents coming for care. For adolescents enrolled in Child Health Plus A (Medicaid), covered benefits include the cost of transportation to and from a health care provider. The question remains whether adolescents and the clinics that serve them are aware of this Child Health Plus A benefit.

Health Care Environments: Recommendations

Although CCC recognizes that many of the clinics interviewed have attempted to accommodate adolescent preferences and interests, our interviews identified a number of structural and physical barriers that influence an adolescent's decision to obtain care at the clinics interviewed. These barriers include limited adolescent-only hours and space, the imposition of visit and medication fees, and the lack of transportation assistance. To address these barriers, CCC recommends that:

- The Governor, the New York State Legislature, and the NYS DOH should follow the lead of HHC and work together to explore possible mechanisms for enabling

adolescents to obtain health care free of charge.

Implementation of the proposal to create Child Health Plus A coverage for adolescents seeking confidential health services, as recommended earlier in this report, would enable adolescents to obtain health care and provide clinics with reimbursement for services rendered.

- The Governor and the New York State Legislature should expand benefits for Child Health Plus B to include transportation as a covered benefit for enrolled children and adolescents. The NYS DOH should notify Child Health Plus A enrollees, managed care plans, and other providers serving children enrolled in Child Health Plus A of the transportation benefit, and mandate that they provide notice to all staff about the benefit as well. NYC DPH should work with managed care plans and HHC to reduce the administrative burden of seeking reimbursement for these benefits, and promote more routine use of the transportation benefits.
- As a complement to the NYS DOH Adolescent Health Initiative proposed earlier in this report, managed care plans, HHC, and the Greater New York Hospital Association should work together to develop special marketing campaigns to inform adolescents and their families about available services and the location of adolescent health services, and design waiting and examination rooms for adolescents that are physically distinct and separate from areas used to serve patients of other ages.

In 1999, 808,763 adolescents 10-18 years of age resided in New York City's five boroughs, and comprised approximately ten percent of the City's population.⁴¹ Health indicators show that this population of children is at-risk of serious health and mental health problems, including assault-related injuries and deaths, contracting sexually transmitted diseases, including HIV/AIDS, depression, suicide and many others. Adolescents are also more likely than most of their younger peers to lack health insurance. Although health insurance coverage increases the likelihood that an adolescent will obtain the health care they need, current policies and the organization and delivery of adolescent health services often makes accessing available health care services a challenging endeavor for New York City adolescents.

The findings presented in this study demonstrate the need for a concentrated effort among policy-makers, health care providers, managed care plans, school officials, parents/caregivers, and child and family advocates to reduce the barriers confronting adolescents who attempt to seek health care. As the pioneer in the expansion of children's health insurance, New York State has a record of being at the forefront of children's health issues and New York City has risen to the challenge of enrolling more and more children and adolescents in health insurance. Although CCC recognizes the efforts by New York State and New York City to work toward improving access and

quality of primary and preventive care to adolescents, increased attention and resources must be devoted by the Governor, the New York State Legislature, the NYS DOH, the NYC DPH, and HHC to developing a primary and preventive health care system that addresses the unique developmental needs and health and mental health risks of adolescents, provides them with the health education and information needed to make sound health and behavioral decisions, informs them about where to go for care, and ensures access to quality health services.

In a time of rising health care costs, the creation of adolescent-only health clinics will present a formidable challenge to health care providers. However, efforts to develop uniform adolescent-specific health protocols, to ensure compliance with New York State laws guaranteeing adolescents the right to certain confidential health services, to inform adolescent health providers and adolescents about these rights, to enhance training opportunities for health and mental health professionals serving adolescents, to increase health education and outreach to adolescents, and to enable adolescents to self-enroll in health insurance for confidential services would likely ease access to care and produce positive adolescent health and mental health outcomes. Without these improvements, thousands of adolescents in New York City will continue to delay, or forego altogether, needed health care and increase their risk of developing serious health and mental health problems. Investing the resources in primary and preventive adolescent care and redesigning available services now will reduce the long-term health and social costs to New York City and its adolescents.

⁴¹ *Keeping Track of New York City's Children*, Citizens' Committee for Children of New York, Inc. (2000), Appendix A, pp. 150-151.

APPENDIX A

CITIZENS' COMMITTEE FOR CHILDREN OF NEW YORK, INC.

Task Force on Adolescent Health

SITE VISIT QUESTIONNAIRE

Thank you for taking the time to meet with us to discuss the health services that you provide to adolescents. Citizens' Committee for Children of New York, Inc. (CCC) is a child advocacy organization that has been advocating for New York City's children for 57 years in the areas of health, mental health, child welfare, housing, child care, education, income support and youth services. We are making site visits to twenty-two programs as part of a study of adolescent health care in New York City. Information collected during this visit will be used in the study and in CCC's advocacy efforts on behalf of adolescents and adolescent health care providers. Please know that no administrator, staff person, or patient will be identified by name in any CCC publication of advocacy efforts. For purposes of this interview, an adolescent refers to an individual between 11 and 21 years of age.

GENERAL INFORMATION (to be completed by CCC Task Force Members Prior to Visit)

Name of Program _____

Address: _____

Name and Title of Program Representative(s) Interviewed:

Phone: _____

Name(s) of CCC Volunteer(s) completing questionnaire:

Licensing

1. In which of the following settings is your program licensed to provide health services? (check all that apply):

- ☐ Hospital
- ☐ School
- ☐ Neighborhood satellite
- ☐ Free-standing clinic
- ☐ Other, please describe:

2. Is your program formally affiliated with a hospital?

- ☐ No
- ☐ Yes. In what ways does your program benefit from that affiliation (check all that apply):
 - ☐ Funding
 - ☐ Administration
 - ☐ Medical malpractice insurance coverage
 - ☐ Ancillary services (such as ordering supplies, transportation of lab tests, etc.)
 - ☐ Specialty Services
 - ☐ Personnel
 - ☐ Other, please explain:

3. Is your program licensed to provide the following services (check all that apply):

- ☐ Primary and preventive health services
- ☐ Mental health services
- ☐ Dental services
- ☐ Other, please explain:

Services

4. Which of the following **medical services or screenings** does your program provide (check all that apply):
- ☐ Routine check-ups
 - ☐ School/activity/employment examination
 - ☐ Immunizations
 - ☐ Diagnosis and treatment of acute illness
 - ☐ Follow-up care for chronic health problems
 - ☐ Dermatology
 - ☐ Gynecological examinations (circle): pap smears and pelvic examinations
 - ☐ General oral health examinations
 - ☐ Screening for eating disorders
 - ☐ Hearing screenings
 - ☐ Health related groups
 - ☐ Vision screenings
 - ☐ Developmental assessments
 - ☐ Neurological assessments
 - ☐ Screening for mental health problems
 - ☐ Screening for physical/sexual abuse
 - ☐ Screening for substance abuse problems
 - ☐ Screening for learning disabilities
 - ☐ Other, please list:

5. Which of the following **reproductive health services or screenings** does your program provide (check all that apply):
- ☐ Condom distribution
 - ☐ Distribution of contraception (circle): oral contraception; emergency contraception; Depo Provera, Norplant, IUDs
 - ☐ Abortions
 - ☐ HIV/AIDS testing & counseling
 - ☐ Pregnancy testing & options counseling
 - ☐ Other, please list:

- ☐ None of the above

6. Which of the following **mental health services or screenings** does your program provide (check all that apply):
- ☐ Crisis intervention
 - ☐ Mental health diagnosis
 - ☐ Psycho-social assessments
 - ☐ Psychotherapy (circle): individual; family; group
 - ☐ Psycho-educational groups
 - ☐ Screening for violence
 - ☐ Screening for past or present physical/sexual abuse
 - ☐ Screening for substance abuse/alcohol problems
 - ☐ Substance abuse treatment
 - ☐ Screening for family or relationship problems
 - ☐ Screening for school-related problems
 - ☐ Other, please explain:

 - ☐ None of the above
7. Does your program have specific services for adolescents with special needs?
- ☐ No
 - ☐ Yes. Please explain the services:

8. Are there additional services **not currently provided** by your program that you think would enable your program to better address the health and mental health needs of adolescents?
- ☐ No
 - ☐ Yes. Please describe the services and the barriers to expanding your program's scope of services to include them.

9. How many minutes is a primary care practitioner scheduled to spend with an adolescent during an initial visit?
- ☐ 0-15 minutes
 - ☐ 15-30 minutes
 - ☐ 30-45 minutes
 - ☐ More than 45 minutes
10. How many minutes does a primary care practitioner usually spend with an adolescent in an initial visit?
- ☐ 0-15 minutes
 - ☐ 15-30 minutes
 - ☐ 30-45 minutes
 - ☐ More than 45 minutes

-
11. Other than a primary care practitioner, does an adolescent meet with any other staff during an **initial visit**?

☐ No

☐ Yes. Please identify the staff positions, and the purpose and length of the meetings.

Continuity of Care

12. Does your program assign a primary care practitioner to adolescents who visit your program?

☐ No

☐ Yes. How likely is it that an adolescent will receive care from his or her assigned primary care practitioner when visiting your program?

☐ Very Likely

☐ Likely

☐ Unlikely

☐ Very Unlikely

13. Are primary care providers accessible by telephone for 24-hour follow-up calls by adolescents?

☐ Yes

☐ No

Does your program make other staff available for this purpose?

☐ Nurse

☐ Nurse Practitioner

☐ Physician

☐ Physician-in-training

☐ Physician Assistant

☐ Health Educator

☐ Social Worker

☐ Other, please explain:

☐ None of the above

14. Does your program make **referrals** to outside service providers: .

☐ No

☐ Yes.

(a) To which of the following providers or services does your program make referrals (check all that apply):

- ☐ Dentists
- ☐ Orthodontists
- ☐ Community mental health services
- ☐ Other primary care providers
- ☐ Pregnant and parenting teen programs
- ☐ Reproductive/family planning services
- ☐ Specialty medical services
- ☐ Substance abuse services
- ☐ Vocational/job training programs
- ☐ After-school or other youth development programs
- ☐ Sports programs
- ☐ Other, please explain:

(b) Does your program have written guidelines for making referrals to outside service providers?

☐ No

☐ Yes. May we have a copy of the guidelines?

15. Does your program **follow-up on referrals** made to an outside service provider?

☐ No

☐ Yes.

(a) What type of follow-up is provided?

- ☐ Letter to adolescent
- ☐ Letter to provider
- ☐ Phone call to adolescent
- ☐ Phone call to provider
- ☐ Appointment with adolescent
- ☐ Another referral if the linkage fails
- ☐ Other, please explain:

(b) Which staff member is responsible for follow-up on referrals?

- ☐ Administrative staff
- ☐ Nurse
- ☐ Nurse Practitioner
- ☐ Physician
- ☐ Physician-in-training
- ☐ Physician Assistant
- ☐ Social worker
- ☐ Other, please list titles:

16. Does your program obtain records relating to the services provided to a patient following a referral to an outside service provider?

- ☐ Sometimes
- ☐ Always
- ☐ Never

Adolescent Health Problems and Health Education

17. In general, why do adolescents first come to your program?

- ☐ Reproductive health reasons
- ☐ Illness
- ☐ Mental health problems
- ☐ School/activity/sports examination
- ☐ Annual check-up
- ☐ Working papers
- ☐ Other, please explain:

18. Please list the five most frequent health related problems presented by the adolescent population that visits your program in descending order of prevalence:

- 1.

- 2.

- 3.

- 4.

- 5.

19. Please list the five most frequent mental or behavioral health related problems presented by the adolescent population that visits your program in descending order of prevalence:

- 1.

- 2.

- 3.

- 4.

- 5.

20. How is health education information communicated by your program to adolescents (check all that apply)?

- ☐ Presentations (circle): schools; community-based organizations; juvenile detention facilities; other _____
- ☐ Distribution of literature in the following location(s) (circle): program premises; schools; community-based organizations; juvenile detention centers; other _____
- ☐ Posters (circle): program premises, schools, public transportation, community-based organizations, juvenile detention centers, other _____
- ☐ Verbally by health care provider
- ☐ Website
- ☐ Other, please explain: _____

21. Do your program's health education efforts provide information about the following topics:

- ☐ Breast/testicular self-examination
- ☐ Acne
- ☐ Cardiovascular health
- ☐ Depression/Suicide
- ☐ Eating Disorders
- ☐ Cholesterol Management
- ☐ Gang involvement
- ☐ HIV/AIDS
- ☐ Nutrition
- ☐ Obesity
- ☐ Parenting for teens
- ☐ Physical Fitness
- ☐ Pregnancy prevention
- ☐ Safety/Accident prevention
- ☐ Sexual activity
- ☐ Sports Injuries
- ☐ Scoliosis
- ☐ Smoking cessation
- ☐ Sexually transmitted illness
- ☐ Substance abuse prevention/treatment
- ☐ Violence
- ☐ Other, please list: _____

☐ None of the above

22. Which of the following languages is used by your program to convey health education information (check all that apply):

- ☐ English
- ☐ Spanish
- ☐ Chinese
- ☐ Russian
- ☐ Other, please list languages:

23. What additional steps could be taken by your program, the government, and/or advocacy organizations to help adolescents seek more regular health care and remain healthy?

Outreach

24. What methods of outreach does your program use to inform adolescents about your services (check all that apply):

- ☐ Fliers
- ☐ Direct mailings to residences
- ☐ Peer education
- ☐ Website
- ☐ Presentations: (Circle): school; community-based organization; faith-based organizations, other

- ☐ Advertisements: (Circle): school newspaper; local newspaper; phone book; health directories; public transportation, other

- ☐ Other, please explain:

25. What method of outreach has resulted in the largest number of adolescent visits to your program?

26. Does your program have peer educators?

- ☐ No
- ☐ Yes. Does your program provide peer educators with:
 - ☐ Ongoing training
 - ☐ Monetary Compensation
 - ☐ Other, please describe:

27. Once an adolescent has visited your program, what steps are taken to encourage the adolescent to return for health care in the future?

- ☐ Telephone call
- ☐ Letter
- ☐ E-mail
- ☐ Home visit
- ☐ Appointment card
- ☐ Other, please explain:

- ☐ No effort made

28. Does your program target its outreach to any of the following adolescent populations?

- ☐ Female
- ☐ Male
- ☐ Homeless/runaway youth
- ☐ Gay/lesbian/transgender youth
- ☐ Immigrant youth
- ☐ Geographic location. Please identify which locations:

- ☐ Adolescents with special needs:

- ☐ Chronic illness
- ☐ Behavioral/mental health problems
- ☐ HIV/AIDS
- ☐ Cystic fibrosis
- ☐ Sickle cell anemia
- ☐ Physical disabilities
- ☐ Other, please explain:

- ☐ Other targeted populations:

Access to Services

29. What services provided by your program require an adolescent to obtain **parental consent** (check all that apply):

- ☐ Primary care
- ☐ Emergency medical care
- ☐ Sports/ activities/ work/school entrance physicals
- ☐ Immunizations
- ☐ Sexually transmitted illness testing
- ☐ Sexually transmitted illness treatment
- ☐ Pregnancy termination
- ☐ Family planning
- ☐ Gynecological examinations
- ☐ Mental health services
- ☐ Reproductive health services
- ☐ HIV/AIDS testing
- ☐ HIV/AIDS treatment
- ☐ Other, please explain:

☐ None of the above

30. Does your program have a parental consent form?

☐ No

☐ Yes. (a) What language(s) is the parental consent form printed in (check all that apply):

- ☐ English
- ☐ Spanish
- ☐ Chinese
- ☐ Russian

☐ Other, please list languages:

(b) May we have a copy of the form?

31. Does your program attempt to engage the parents of adolescents that visit your program?

☐ No

☐ Yes. Please explain what and when efforts are made: _____

32. Does your program provide care to uninsured adolescents on an ambulatory care basis?
- ☐ No
- ☐ Yes. How does your program secure payment for these services (check all that apply):
- ☐ No fees are charged to the patient
- ☐ Flat fee per visit in the amount of \$_____
- ☐ Sliding scale per visit that ranges from \$_____ to \$_____
- ☐ Grant funding
- ☐ Other, please explain:
- _____
- _____
- _____

33. What are your program's days and hours of operation?
- ☐ Monday _____ a.m. _____ p.m.
- ☐ Tuesday _____ a.m. _____ p.m.
- ☐ Wednesday _____ a.m. _____ p.m.
- ☐ Thursday _____ a.m. _____ p.m.
- ☐ Friday _____ a.m. _____ p.m.
- ☐ Saturday _____ a.m. _____ p.m.
- ☐ Sunday _____ a.m. _____ p.m.

34. Does your program have adolescent exclusive hours?
- ☐ No
- ☐ Yes. How many hours per week are designated for adolescents?
- ☐ 0-8 hours/week
- ☐ 8-16 hours/week
- ☐ 16-24 hours/week
- ☐ 24-32 hours/week
- ☐ More than 32 hours per week

35. What are the hours of high usage by adolescents?
- _____

36. What is your program's appointment policy (check all that apply)?
- ☐ Scheduled appointments preferred
- ☐ Scheduled appointments only
- ☐ Block appointments
- ☐ Walk-in appointments
- ☐ Emergency emergency
- ☐ Other, please describe:
- _____
- _____
- _____

Are adolescents accepted as walk-in or emergency appointments triaged by staff to determine urgency of their health related needs?

- ☐ Yes
- ☐ No

37. What is the waiting time to obtain the following kinds of appointments:
- ☐ Primary care (circle): 0-1 days; 2-3 days; 4-7 days; more than 7 days
 - ☐ Mental Health (circle): 0-1 days; 2-3 days; 4-7 days; more than 7 days
 - ☐ Reproductive Health (circle): 0-1 days; 2-3 days; 4-7 days; more than 7 days
38. Does your program provide after hours care?
- ☐ Yes
 - ☐ No
39. How close is the nearest subway station or bus stop to your program?
- ☐ 0-4 blocks
 - ☐ 5-7 blocks
 - ☐ 8-10 blocks
 - ☐ more than 10 blocks
40. Does your program provide transportation assistance to adolescents?
- ☐ No
 - ☐ Yes. What type(s) of transportation assistance does your program provide (check all that apply)?
 - ☐ Round trip subway/bus fare
 - ☐ One way subway/bus fare
 - ☐ Money for carfare
 - ☐ Other, please describe:

Confidentiality

41. Does your program have a policy regarding confidentiality?
- ☐ No
 - ☐ Yes. (a) Please describe the policy:

(b) May we have a copy of it?
42. How does your program inform an adolescent about confidentiality (check all that apply)?
- ☐ Literature on the program premises
 - ☐ Posters on the program premises
 - ☐ Verbally by health care provider
 - ☐ Other, please explain:

43. Does your program follow-up with an adolescent who **fails to show for a scheduled appointment**?

☐ No

☐ Yes. (a) How does your program conduct the follow-up (check all that apply)

☐ Home visit

☐ Letter

☐ Phone call

☐ E-mail

☐ Beeper message

☐ Alternate contact number

☐ Other, please explain:

(b) Which staff member is responsible for follow-up?

☐ Administrative staff

☐ Nurse Practitioner

☐ Nurse

☐ Physician's Assistant

☐ Physician

☐ Physician-in-training

☐ Social worker

☐ Health educator

☐ Other, please list titles:

44. Does your program follow-up with an adolescent who has an **abnormal test result** (such as an irregular pap smear or a positive test for a sexually transmitted illness)?

☐ No

☐ Yes. (a) How does your program conduct the follow-up (check all that apply)

☐ Home visit

☐ Letter

☐ Phone call

☐ E-mail

☐ Beeper message

☐ Alternate contact number

☐ Other, please explain:

(b) Which staff member is responsible for follow-up?

- ☐ Administrative staff
- ☐ Nurse Practitioner
- ☐ Nurse
- ☐ Physician's Assistant
- ☐ Physician
- ☐ Physician-in-training
- ☐ Social worker
- ☐ Health educator
- ☐ Other, please list titles:

45. What barriers currently impede adolescents from accessing health services?

What would help to eliminate the barriers that you have identified?

Resources/Facilities

46. Does your program have designated space for providing adolescent health services?

- ☐ Yes
- ☐ No

47. Are adolescent health services provided in the following types of physical space:

- ☐ Separate self-contained offices
- ☐ Spaces separated by partitions or curtains
- ☐ Other, please explain:

48. Does your program have the equipment to conduct gynecological examinations and sexual transmitted illness (STI) screenings?

- ☐ Gynecological examination equipment
- ☐ STI screening equipment

49. Does your program have a pharmacy on-site?

- ☐ Yes
- ☐ No

-
50. Does your program prescribe or distribute medication to adolescents?
- ☐ Prescribe
 - ☐ Distribute
51. Does your program experience shortages in supplies on a regular basis?
- ☐ No
 - ☐ Yes. What types of supplies?
 - ☐ Pharmaceuticals
 - ☐ Contraception
 - ☐ Laboratory supplies
 - ☐ Medical supplies
 - ☐ Vaccines
 - ☐ Office supplies
 - ☐ Cleaning supplies
 - ☐ Other
-

Training

52. Does your program require staff to participate in cultural sensitivity training?
- ☐ No
 - ☐ Yes. (a) Is cultural sensitivity required for:
 - ☐ All staff
 - ☐ Professional health care staff
 - ☐ Professional mental health care staff
- (b) Does your program provide the training on-site:
- ☐ Yes
 - ☐ No. Where is it provided?
-
- (c) How often is the training required?
- ☐ Once a year
 - ☐ Twice a year
 - ☐ Other, please explain:
-
53. Does your program require staff to participate in training on adolescent issues?
- ☐ No
 - ☐ Yes.
 - (a) Is the training required for:
 - ☐ All staff
 - ☐ Professional health care staff
 - ☐ Professional mental health care staff
 - (b) Does your program provide the training on-site:
 - ☐ Yes
 - ☐ No. Where is it provided?

(c) How often is the training required?

- ☐ Once a month
- ☐ Every three months
- ☐ Every six months
- ☐ Every nine months
- ☐ Once a year
- ☐ Other, please explain:

(d) Please list the topics addressed in training(s) provided in 2000.

54. Does your program employ bilingual staff?

- ☐ No
- ☐ Yes. How many staff members are bilingual? _____
Professional Staff: _____
Administrative Staff: _____

55. What languages are spoken by staff at your program?

- ☐ English
- ☐ Spanish
- ☐ Russian
- ☐ Chinese
- ☐ Other, please indicate language(s):

Utilization

56. Does your program solicit feedback from **adolescents** regarding quality of services?

- ☐ No
- ☐ Yes. Does your program use any of the following data collection methods?
 - ☐ Meetings
 - ☐ Phone calls
 - ☐ Patient Satisfaction Surveys
 - ☐ Other, please describe method:

57. Does your program solicit feedback from **parents** regarding quality of services delivered to their adolescent children?

- ☐ No
- ☐ Yes. Does your program use any of the following data collection methods?
 - ☐ Meetings
 - ☐ Phone calls
 - ☐ Patient Satisfaction Surveys

☐ Other, please describe method:

Please tell us anything else about your program or experience providing adolescents with health care that our questions did not cover.

Thank you. Our interview is over.

CITIZENS' COMMITTEE FOR CHILDREN OF NEW YORK, INC. *Task Force on Adolescent Health*

DATA QUESTIONNAIRE

Thank you for agreeing to participate in Citizens' Committee for Children of New York's (CCC) study of adolescent health care in New York City. CCC is a child advocacy organization that has been advocating for New York City's children for 57 years in the areas of health, mental health, child welfare, housing, child care, education, income support and youth services. As part of this study, we are conducting in-person interviews at twenty-two sites throughout New York City and are requesting each provider to complete this questionnaire, which seeks statistical questions about your **community-based program** that may not be easily answered during an interview. Information collected as a result of your participation will be used in a published study and in CCC's advocacy efforts on behalf of adolescents and adolescent health care providers. Please be assured that no administrator, staff person, or patient will be identified by name in any CCC publication or advocacy efforts. For purposes of this study, an adolescent refers to an individual between 11 and 21 years of age.

Contact Information

Name of Community-based Program _____

Name and Title of Program Representative who completed the questionnaire:

Phone: _____

Demographics of Patient Population

1. What was the total number of patients under the age of 22 that visited your community-based program in 2000?

2. What proportion of the patients served by your community-based program in 2000 were adolescents ranging in age from 11-21? _____ %
3. Of the total number of adolescents served by your community-based program in 2000, please provide the following demographic information:
 - (a) Race/ethnicity:
_____ % African-American
_____ % Asian
_____ % Caucasian
_____ % Hispanic
_____ % Other _____
 - (b) Country of Origin
_____ % Foreign-born adolescents
 - (c) Gender/age
_____ % Females aged 11-14 years
_____ % Females aged 15-17 years
_____ % Females aged 18-21 years
_____ % Males aged 11-14 years
_____ % Males aged 15-17 years
_____ % Males aged 18-21 years
 - (d) Borough of residence
_____ % Bronx
_____ % Brooklyn
_____ % Manhattan
_____ % Queens
_____ % Staten Island
_____ % Other, please list counties: _____

Insurance Data

4. What proportion of the adolescents that visited your community-based program in 2000 indicated their insurance status as follows:
_____ % Enrolled in Child Health Plus A (Medicaid)
_____ % Enrolled in Child Health Plus B (Child Health Plus)
_____ % Enrolled in a commercial plan
_____ % Uninsured
5. Has your community-based program experienced a change in the number of insured adolescents between 1997 and 2000?
☐ Increased
☐ Decreased
☐ No change

Utilization

6. What was the total number of adolescent visits to your community-based program in the following years:

1997 Total # of visits _____

1999 Total # of visits _____

1999 Total # of visits _____

2000 Total # of visits _____

7. What is the average number of times an adolescent visits your community-based program each year?

Female _____

Male _____

8. What proportion of adolescents return for follow-up care after an initial visit?

_____ % Female

_____ % Male

Staffing

9. Please indicate the number of staff employed by your community-based program as well as the full time equivalent slot they represent in the following categories:

☐ Caseworker # _____ FTE _____

☐ Social Worker (M.S.W.) # _____ FTE _____

☐ Health educator # _____ FTE _____

☐ Nurse # _____ FTE _____

☐ Nurse practitioner # _____ FTE _____

☐ Nurse's aid # _____ FTE _____

☐ Nutritionist # _____ FTE _____

☐ Physician-in-Training # _____ FTE _____

☐ Physician (pediatrician) # _____ FTE _____

☐ Physician (adolescent specialist) # _____ FTE _____

☐ Physician (family practitioner) # _____ FTE _____

☐ Physician (internist) # _____ FTE _____

☐ Physician assistants # _____ FTE _____

☐ Child & Adolescent Psychiatrist # _____ FTE _____

☐ Child & Adolescent Psychologist # _____ FTE _____

☐ Other, please list titles/positions and indicate total number of hours worked each week:

_____ # _____ FTE _____

_____ # _____ FTE _____

_____ # _____ FTE _____

_____ # _____ FTE _____

Funding/Financial Support/Licensing

10. Assuming an adolescent self-declares as uninsured, what is the source of funding for medication prescribed and distributed to adolescents by the community-based program? Please explain:

11. What proportion of funding for your community-based program is derived from:

- | | |
|---|--|
| ☐ Billing Patient _____% | ☐ Hospital Funds _____% |
| ☐ Billing Insurance _____% | ☐ State Funds _____% |
| ☐ Federal Funds _____% | ☐ City Funds _____% |
| ☐ Private Grants _____% | |
| ☐ Other, please explain: | |

12. Please indicate the source of revenue provided by your program for the following services:

- ☐ Primary care (circle): federal funding; state funds; city funds; private funds; patient billing; insurance billing; hospital funds; other, please explain:

- ☐ Mental Health (circle): federal funds; state funds; city funds; private funds; patient billing; insurance billing; hospital funds; other, please explain:

- ☐ Reproductive Health (circle): federal funds; state funds; city funds; private funds; patient billing; insurance billing; hospital funds; other, please explain:

- ☐ Oral Health (circle): federal funds; state funds; city funds; private funds; patient billing; insurance billing; hospital funds; other, please explain:

- ☐ Health Education (circle): federal funds; state funds; city funds; private funds; patient billing; insurance billing; hospital funds other, please explain:

15. Please indicate the type of license(s) your program has obtained to provide the following services:

- ☐ Primary care _____
- ☐ Mental Health _____
- ☐ Oral Health _____
- ☐ Reproductive Health _____
- ☐ Other, please explain: _____
- _____
- _____

Thank you.

QUESTIONS FOR ADOLESCENT HEALTH TEEN FOCUS GROUP

Finding a Place to Get Health Care

1. How do teenagers find out about where to go for health care?
2. Where do teenagers go to get health care?
3. Are the places teenagers go for health care located in the neighborhood or community where they live, or do they travel to other communities?
4. What do you think are the reasons some teenagers do not get health care when they think they need it?

What kind of environment do health care providers create for teenagers

5. Do teenagers feel that doctors and nurses listen carefully to their concerns and take their concerns seriously?
6. Do teenagers find age-appropriate information (such as pamphlets on health related issues or magazines) displayed in waiting areas or examination rooms?
7. Do you think teenagers prefer walk-in appointments rather than having to schedule an appointment for a specific time and day?
8. Do you think teenagers prefer to go to the doctor with or without their parents?
9. How do teenagers feel about a clinic rule that requires a teenager to get parental consent before getting health care?
10. Do you think teenagers that have health insurance always inform a doctor's office that they have insurance?

Talking to health care providers

11. Do teenagers feel comfortable talking to the doctor or nurse about issues, like acne, birth control, STDs, depressed feelings, sex, HIV/AIDS?
12. Do you think teenagers would find it helpful to talk to a counselor or social worker about certain issues related to a health or mental health problem?
13. Do you think the gender of a doctor or nurse matters to teenagers?
14. Do teenagers feel that they leave the doctor's office with the help or treatment they want and need?
15. Do teenagers feel that they leave the doctor's office with the information they want and need?
16. Do you think doctors or nurses talk to teenagers about their right to confidentiality?
17. What would be the best way for a doctor or nurse to contact teenagers after they leave their appointments?
18. Do you think doctors or nurses regularly ask teenagers whether they are sexually active?
19. If you could tell health care providers how to better meet the needs of teenagers, what would you tell them?

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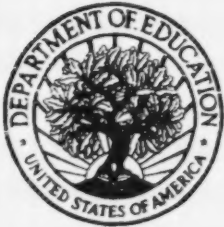
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Citizens' Committee for Children of New York (CCC) is an independent voice for New York City's children. CCC champions children who cannot vote, lobby, or act on their own behalf, especially those who are poor, have special needs or are particularly vulnerable. Our goal is to secure the rights, protections and services children deserve. Many of our activities directly affect the lives of individual children but most of our efforts are spent identifying the causes and effects of disadvantage and poverty, promoting the development of services in the community and working to make public and private institutions more responsive to children. CCC is unique among child advocacy organizations in that citizen members and staff work side-by-side assuming the roles of spokesperson, researcher, coordinator and watchdog for the City's children. Our staff and members include specialists in health, mental health, education, child care, housing, homelessness, income security, child welfare, juvenile justice and child and youth development.

CCC educates New Yorkers about children's issues, publishes reports and papers, collects and disseminates data, provides technical assistance and support to policymakers, service providers, parent and civic groups and monitors the implementation of federal, state and local policies. CCC directs its attention to budgets, legislation, regulations and management of children's programs. CCC provides a community presence by monitoring the availability and quality of services to children and families in New York City neighborhoods. CCC creates and joins coalitions, brokers competing interests and develops action plans to improve conditions for children. CCC helps New Yorkers turn their personal concern for children into action through our Community Leadership Course.

Kids First, New York is a citywide effort to mobilize parents, professionals, policymakers and other citizens to improve conditions for all New York City children. The Kids First, New York campaign adds another dimension to CCC's work to ensure that every child is healthy, housed, educated and safe.

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